PUBLIC HEALTH NURSING

FEBRUARY
1948

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PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

It's All For You

A YOUNG nurse stimulated by the give and take of a group conference summarized it by saying, "Supervisors, executives, nursing organizations, boards of directors, and high powered committees exist only to help the field nurse do a better job with her patient and his family in their home and community. They are all just window-dressing for the field nurse in her work with people." As she glanced at the supervisors and administrators present she blushed with embarrassment. But they did not seem shocked—in fact, she could sense their instant support and her equanimity was restored. The group laughed and the conference ended in the warmth of good fellowship.

This young field nurse had unintentionally stated a simple fact that we all accept, but we need to be reminded of it frequently. With the growing complexity of our work in a time when science had made the world so small, it is easy for nursing executives, teachers, board members and others who do the bulk of the planning and policy forming to become confused by the multitude of demands and responsibilities placed upon them. They sometimes forget the fundamental truths that will help them stay on solid ground.

Our young nurses in the field must hold their heads high and speak up when they think their leaders are straying from reality.

Our leaders' intentions are good and they know the truth when they hear it. They will listen for they know that you are facing hard facts and difficult situations.

The desks at NOPHN headquarters are piled high with letters and reports; the typewriters click and the telephones ring; the committees and boards meet and the minutes are written. The small budget is accepted and stretched to do a big job; the Board and Committee Members Section prepares "Guides for Community Participation in Public Health Nursing"; the School Nursing Section undertakes a study of nursing in colleges; the Nurse-midwifery Section surveys the field to formulate principles of practice in nurse-midwifery; editorials are written and articles prepared for publication in the magazine. Standards are established; functions are outlined; records are devised. The Biennial Convention is planned.

Underneath all this are the intent and the desire to help you who are in the field doing the job of public health nursing—teaching, guiding and giving nursing care to the young, the middle aged and the old in all kinds of families. The beginning and the end of our efforts is to help you give better service.

The structure study of the national nursing organizations is for you. What evolves out of this study will affect you and every nurse in the country and it will also affect every citizen and every community which you serve.

But really to help you, we need to hear from you. And we need your support—moral, intellectual, and financial. Many messages come to us through representatives of your agencies who serve on our Board of Directors and committees. We want to hear directly from you, too. We want to know what you are interested in, what your problems are, what irks you, what pleases you. We want to know how you think you could participate more directly in the national program.

NOPHN is not the northern organization for public health nursing, nor the eastern, nor western, nor southern organization—it is the *National Organization for Public Health Nursing*. This is your organization—and the organization of all those interested and concerned with bringing better health to all the citizens of our broad land.

ANNA FILLMORE, R.N.
GENERAL DIRECTOR

Official Agency Support

THE National Organization for Public Health Nursing has come to mean many things to many people. In the course of a year thousands of requests for help come to NOPHN, and with the passing years, NOPHN finds it has more and more services to render to an ever enlarging group.

The cost of maintaining the National Organization has fallen to a large extent on individual nurses and board members and on voluntary public health nursing agencies. Today when the greatest expansion in public health nursing programs is occurring in official agencies, the conviction is growing that it is reasonable to request greater financial support from this group. Today public health nurses constitute well over 50 percent of the professional personnel of the official health family. In the last decade and a half, public health nurses in state, city and county health departments have more than doubled, increasing from about 5,600 in 1931 to 11,500 in 1947. Public health nurses employed by boards of education increased from 3,000 to 4,650. The number of public health nurses in voluntary agencies, on the other hand, dropped 23 percent—from 6,024 in 1931 to 4,637 in 1947.

In mid-January an appeal for a sustaining service fee, based on the population served and the amount expended for nursing, was formulated and sent to the health officers of about 900 official agencies. Copies of the appeal, of course, were also sent to the supervisory nurses. Many replies have been received. The tenor discernible has been gratifying to the NOPHN and some money has been forthcoming.

Many health officers have said that the request will be taken under consideration and referred to those who control the funds. Others expressed personal approval but explained that the complicated financial structure in the government prohibits the payment of such fees. In some of the latter instances, they have also stated, the way is clear to purchase literature, posters, and other educational materials. Although a few refusals have been voiced, there seems to be a decided acceptance of the NOPHN and understanding and appreciation of the services it renders.

The committee which prepared the appeal letter reviewed these services, especially those from which official fully as much as voluntary agencies benefit. The NOPHN provides information and assistance on numerous problems relating to standards of performance and personnel in public health nursing. Its files of data are current and comprehensive and therefore of specific assistance when such problems require speedy solution. The NOPHN has collected and analyzed information for the use of its members on costs of service, standards of education, personnel policies, community planning, prepayment medical care plans, nursing in industry, and many other topics. Consultation with NOPHN staff specialists is available, at headquarters and in the field. Its periodical literature, reprints, monthly newsletters, and loan folders on 20 different topics offer a further means of keeping up with public health nursing.

Here is an important opportunity for the NOPHN member on the official agency staff to interpret to her health officer what the NOPHN means to her in terms of professional growth. The health officer is not always aware of the relation of the nurses on the health department staff to the national organization. His clear understanding of the situation without doubt will put them in a better position to take full advantage of the many benefits available to them upon request to NOPHN. As Miss Fillmore says on the preceding page the NOPHN is not a sectional organization. Neither is it an organization for only one sector of public health nurses. It is the national organization for public health nurses in all types of agencies and programs, and for all others interested in forwarding the services.

The NOPHN is behind you. Are you behind your national organization?

The Aging, The Aged

By OLLIE A. RANDALL

IT IS AXIOMATIC with those of us who are directly concerned with promoting the public health and welfare, that the measure of public health achieved in any single community, state, or country is determined by the well being of each of its citizens—not by that of any one segment or group of those citizens. So when one examines what is happening to the aging and the aged everywhere about us today, no further evidence is required to convince us that those who have a primary concern in promoting public health have a genuine stake in the aging population and its effects upon the community and community services. Few old people are entirely well, although their illnesses vary widely in seriousness and in the extent of the disabilities they engender. It may then be profitable to glance once more at what are by now almost hauntingly familiar figures—so familiar as at times to have lost their significance as did the cry of "Wolf, wolf!" of the well known fable. Yet the figures should not necessarily be regarded as a danger signal, although it is true that unless all of us take heed of their implications they may some time indicate a threat to the general public health rather than the mere warning they are today.

AGING POPULATION

We are, as a country, aging—not only as individuals but as a population. The trend is very definite. Even the temporary setbacks to its inexorable march which have resulted from early marriages due to a war crisis with an upswing in the birth rate have apparently succeeded in doing little more than to delay by a few years the time when 13 percent or 14 percent of our people will be 65 years of age and over. Before the war, the estimates indicated that by 1980 one in seven persons would be in that age group, but the latest estimates cited in social security reports indicate that 13 percent of us will be in the 65 year and over category by the year 2000. The change in percentage is not sufficiently great, nor is it postponed for a long enough period to make any real difference in our planning at this time.

For us it is exceedingly important to keep in mind several other related figures with regard to this shift—one of these being the proportion of us who will be 45 years of age and over. Here the estimates vary somewhat, but there is general agreement that we can anticipate about 50 percent of our population being in this upper age bracket by 1980. Also, we should remember that while not many more of us are going to reach the great age of 80, 90, or 100, a rapidly increasing percentage of us have a life expectancy at birth of 60 if we are male, and of 67 if we are female—with this upper age limit advancing steadily as science in general and medicine in particular improve and add to their knowledge and skills. No one has as yet discovered, or if he has, has not divulged, the secret of why women outlive men by this rather wide margin of years. To nurses, of whom the greatest number are women, this fact in itself has personal as well as professional interest.

With persons 65 and over making up between 5 and 7 percent of our population at this time, and with the rate of increase in that group 35 percent in the 10-year period, 1930-1940 (almost five times the rate of increase for the rest of the population), we have around us more and more old people who have had salvaged to them more years of life than they could have expected when they were born. The reasons for this are many—and not all of them are entirely due to medical science. Were it not for the great improvement in sanitary engineering and the public health as epidemics have been controlled, and for the new drugs and new technics in medicine

Miss Randall is consultant on services for the aged with the Community Service Society of New York. She also serves as chairman of the Conference Group on the Welfare of the Aged of the Welfare Council of New York City.

and surgery, life expectancy would not have been changed so markedly. It is only fair to state that social progress has admittedly lagged behind this scientific progress. Consequently many of our elderly are today what a nurse in my office the other day called "martyrs to longevity." We are without previous experience of old age, except in isolated instances—without knowledge of it—without skill or resources for meeting its demands—without at present a proper understanding or appreciation of it, either as a community or personal problem.

What then are some of the general factors in an aging population which should have our thoughtful attention? Perhaps the first in importance is that society is not now organized to keep many of us either gainfully or even usefully employed or occupied from 65 years of age on. At present it is even finding persons younger than this nationally established age for automatic retirement ineligible for reemployment, once they have been removed from the active labor market. This fact should give us all pause, for with a culture and an economy in which self-support has been the accepted method of maintenance for a growing number of women as well as men, such a lack of employment raises many questions which go beyond those of financial support, in itself serious and calling for major adjustments. At the present time, national statistics tell us that approximately one third of our aged—those 65 and over—are totally dependent, either upon their families or public support; another third are partially dependent; and only the remaining third are independent. The chances then are two to one that the person of 65 will find himself or herself needing financial assistance from some source or other, with the odds becoming greater as time goes on. Can we prepare adequately for all the hazards implicit in this?

This lowering of income has direct bearing on the future of all of us. Funds will obviously be limited for underwriting the costs of ordinary daily living. True we have a nationwide system of public assistance which guarantees a minimum economic security, and we have a vast and growing public insurance program which also provides, for those in industries now covered by it but not for most professional workers, a further guarantee of protection from the sting of actual poverty, or pauperism as we have known it in the past. However, neither of these is adequate to stand the drain of the most common and most devastating experiences of middle and old age—acute and chronic illness. Both of these forms of support in old age are minimum—with no margin for mounting costs of living, to say nothing of the inroads of the costs of medical and nursing care at a time when they are most apt to occur.

NEW ATTITUDES TOWARD THE ELDERLY

Medical men are being urged to recognize the trend which the meaning of geriatrics—medical services for the aging and the aged—has for them. But it behooves all of us, in a purely selfish sense, in a family sense, in a business or professional sense, and last but not least, in a community sense, to look to the meaning of the aging process. As medicine and the social and other sciences advance, it is gradually being brought home to us that no one of them operates unrelated to the others. Also as our awareness grows of the meaning of the social and emotional lives of individuals in their effects upon physical well-being and therapy, we realize that all aspects of medical care call for teamwork among the several professional groups. Especially is this true in the medical world, for the nursing profession, with any age patient, is the key to the effectiveness of the others. It is also a growing conviction on my part, after a respectable number of years of working with elderly people, that there is not any single person in the hierarchy of professions concerned with patients who is or who can be more effective with old people than the nurse, with special emphasis on the public health nurse. This is very simple to understand when we examine the conditions of and around old people as we know them today.

ILLNESS IN THE AGED

Old age is not a disease of itself, although there is genuine confusion in the minds of many on this point. Let us keep that in mind constantly when we think of old people. But most old people do have some ailment or illness, generally of a chronic nature. As Dr. Bluestone of Montefiore Hospital of New York City recently put it "The problem of the aged has become young, and the problems of

the chronic has become acute." This is the state of affairs which the vast number of the aged among us has created. While obviously there are acute and emergent episodes of illness among the old folk, they are not so frequently a serious problem as are the continuing undramatic chronic illnesses and the accompanying disabilities, which challenge none of our abilities for meeting crises but seem rather to test only our endurance or staying powers.

National figures again tell us that illness, and particularly chronic illness, finds more victims among low income groups than among others. We have already found that about two thirds of our older people are in the dependent or semi-dependent categories, with many of them in the lowest income bracket. Also Dr. Dublin of the Metropolitan Life Insurance Company has given us some very interesting figures as to invalidism. These tell us that older people spend about three times as many days in bed because of illness as do members of lower age groups. The figures for the visits made to policy holders of the Metropolitan Life Insurance Company bear out the increase in chronically ill persons of whom a large percentage are older persons. In 1925, of the calls made by nurses 5 percent were made upon these patients; in 1945, about 20 percent. The Visiting Nurse Society of New York has reported that not only were more patients with chronic illness—in the upper age brackets—called upon, but that there were more calls for each patient, and more time for each call.

TWO TASKS

With this information before us it appears obvious and inevitable that much of our nursing service both now and in the future, will be needed for these persons. Two tasks seem to be outlined clearly: one that of trying to care for the aged *now,* and the other to derive from that experience much that will be helpful in our work of tomorrow, when hopefully many of the tragedies of today's old age may be prevented by a more intelligent approach to health care in earlier years. And it is in both of these tasks—on the near and the far horizon—that the public health nurse can be of immeasurable value.

We are told that 70 percent of the chronic and the aged patients can be cared for in their own homes. Other things being equal, they will, with proper care, be happier and better off there than elsewhere. It is common knowledge that today our hospitals, our institutions, our nursing homes, good, bad, and indifferent, are bulging with patients who could be well cared for at home were there adequate auxiliary services, such as visiting nurse and housekeeper services or good home nursing training, with proper understanding on the part of the family as to what is needed for the elderly patient in the home. We are learning that medical and nursing care, given to patients in their own homes, if the patients are welcome there, is more efficacious for them and even less expensive. Public health nurses who work directly with persons and families in their own homes have a rare opportunity to help educate the individual patient in his own interest and care as well as to educate other members of the family. Nurses can teach not only techniques of nursing care of the person now old and sick, but positive and preventive health measures which may tend to reduce in years ahead the alarming percentages of invalidism we have today. Education is much more acceptable when it comes with the specific services which nurses give. The reduction of physical discomfort, very difficult for patient and family to sustain, is so direct a service that words of training and advice given by the nurse at the time are more readily received than when they come from other more impersonal sources.

FUNCTIONAL CAPACITY OF PATIENT

As we study persons now chronically ill, especially persons who are older, we are impressed with the number for whom the illness is not the primary factor to be considered, but rather the disability resulting from it. Even this, as we are slowly coming to realize, may also be minimized in the future, if what we are learning about rehabilitation is applied to the aged along with other handicapped persons. Public health nurses, with their knowledge of what the functional capacity of a patient is—what he can do and what he cannot do—in spite of the diagnosis which is usually quite frightening to the patient and to his family may succeed where the doctor fails, in helping all of them work toward a degree of self-help and activity which might not otherwise be possible. It is a growing need

for us all to have physicians give us this activity or functional rating, along with the diagnosis, according to modern knowledge and in the light of the potentialities of modern therapy and the patient's willingness to cooperate. Dr. Howard Rusk, the other day, in discussing the program of rehabilitation for civilian patients, said, "The ultimate therapeutic objective of medicine is the preservation of the personal dignity of the patient." This is needed for the aging and the aged patient in a far deeper sense than for any other, for our modern life serves to deprive them of their personal status and dignity. Complexities of living, the tempo of the atomic age, for which the young no less than the elderly have not been prepared, have thrown old folks out of the places they have held in the community, whether that be in their families, in their work, or in any of the other phases of social activity. When in addition to this "loss of face" he suffers loss of health, with the personal indignities which this can impose, the effect upon him psychologically may mean actual bitterness if not tragedy. This calls for exceptional understanding on the part of all who come in contact with him—and patience is the virtue greatest in demand and apt to be the scarcest commodity available.

UNDERSTANDING THE INDIVIDUAL

Old age has many disappointments in it, for all of us know that it brings losses of many kinds, generally speaking. Yet each of us lives in the hope that he may be one of those born under a star lucky enough to miss most of its hardships. Old age is different for each of us. Our reactions to it are as individual as they can possibly be. Our past behavior determines in large measure whether those reactions will be resentful, fearful, strong or weak, stable or unstable. And so with our elderly patient we can be much more tolerant if we take the time and patience to know him, not only as we find him today and through his own eyes, but as he was in the past and through the eyes of his family and friends—for families can be worn down to prejudices, unfair to everyone.

Sickness and other pressures today are placing such a strain upon family life, when there are several generations living together, that frictions easily develop into prejudices or open antagonisms. Many of these reflect feelings of guilt upon the part of members of either or both generations. To help the patient one has to seek to help all the family too. In spite of the great shortage of places in which elderly sick persons can be accommodated outside the home, it is often well to try to work out, for the ultimate good of all involved in situations which grow in tension, an arrangement which plans for a separation, even though each separation may not be permanent. Nurses with good social sense, combined with their knowledge of the health needs, can render service of untold value in the interpretation of the gains such a plan may secure, when it is in conflict with either the family attitude or the social attitudes in the community. It is often fear of what the neighbors will think which persuades families to continue living plans which are unsatisfactory and almost unbearable, emotionally speaking.

Nurses have another fine opportunity by teaching both patients and families to give the right weight to complaints and "miseries" which have always been thought to be essential in old age. By running them to the ground, so to speak, one can judge whether such complaints are merely habit, an attention-getting device to be found in the old as well as the young, or whether they are actually caused by illness which can be eased or corrected. One old lady of my acquaintance was put off for months by an unsympathetic family as a neurasthenic. When a really interested person effected a thorough health examination, with no tests barred, a fractured vertebra was discovered to be a very valid basis for any and all complaints. One public health nurse, whom I have often quoted, once said to me that she had decided that all bad dispositions in old people were the result of ill health. This is not the whole truth, nor does the old saying that old people are nothing but a set of bad habits tell the whole story either. But many fretty, crotchety dispositions will be improved if even minor ailments and annoying pains are given some relief. Occasionally just the attention helps! With the emphasis on positive health which we might all have if we are to be even a slight degree healthier in our old age than those who have already reached their threescore and ten in the year 1947, public health nurses can be of great as-

sistance in encouraging full and thorough health examinations at regular and frequent intervals. These should minimize the risk of undiscovered causes of aches and pains, and make possible a much greater degree of physical comfort. This is dear to us at any time of life, but becomes almost priceless to us in later years.

One other asset which is being placed at our disposal is our new knowledge of nutrition and its usefulness both in preventing some of our illnesses, formerly regarded as inevitable, and in correcting some of the discomforts of old age. In spite of the high cost of food today, it is still prudent and economical to care for ourselves through proper nutrition rather than to remedy by medication the ravages wrought by years of poor food habits. Habits are hard to change in old age. And somehow the poorer they are, the more difficult they are to give up. However, public health nurses are again in a strategic position, while in the homes for some specific and concrete health service which the patient and the family are eager to have, to make the information about what is needed for proper nutrition acceptable, if not "palatable." War advertising and rationing and today's food conservation news have made many of us, young and old, more nutrition conscious. Ultimately this may be of inestimable value to our older people and to us. Much more can be learned about this phase of health in our old age, but with work on it, planned particularly for public health nurses, we have already made a beginning.

NEEDS AND OPPORTUNITIES

There is need for authentic material on good nursing technics for the chronically ill person, handicapped by age as well as illness, in the hospital, nursing homes, and in the patient's own home. More services must be geared to the requirements of the families and the patients at home. Manuals are needed for teaching the lay person the services he can give without danger to the patient. The elderly person of today needs care—and without hospitals available that care must be provided at home. The elderly person of today and tomorrow is a person whose funds for care will be limited. The highly paid, highly skilled nurse will, in view of the limitations of personnel and financial resources, not be on call for individual service on a private basis for many of them. She will be needed to train, to educate, and to direct. She will need to have an appreciation of the social forces which are bringing about this increased demand. She will need a sensitivity to the needs of the individual, to the frustrations and deprivations which later years mean and bring, and to the aggravation of emotional disturbance which sickness and its attendant disabilities generally create. Her opportunity for service among elderly people which is trying but rewarding is already without precedence. It promises to increase at such a rapid pace that all her imagination, her skills, her training will be used to the utmost if the old people of tomorrow are to be healthier and happier than they are today.

"HELP YOUR PUBLIC HEALTH NURSE HELP YOUR COMMUNITY"

With this theme, plans are moving forward for National Public Health Nursing Week, April 11-17, under the aegis of 3,000 local committees in communities throughout the United States.

Of the purposes of this nationwide observance, Ruth Hubbard, president of the National Organization for Public Health Nursing states:

"Our first objective in 1948 is to continue our efforts to make the work of the public health nurse known to every person in these United States so that no individual will be in need of the service of the public health nurse and be at the same time unaware of her existence. Our second objective is to recruit to this branch of nursing an increasing number of young women who will find challenge and satisfaction in the opportunities for service which it offers."

To help communities observe the Week effectively, NOPHN has prepared a special kit which includes suggestions for newspapers, magazine, and radio use; a 3-act play for school groups; samples of new leaflets; and many other useful items. Price for each kit is $1 if sent by third-class mail; $1.25 if by first-class. Also available are a new poster, 12 for $3.50; "Going My Way?" a new vocational leaflet, $3.50 per 100; and "America's Health Hunters," a cartoon leaflet in 6 colors, $7.50 per 1,000. Send to NOPHN at 1790 Broadway, New York, for data about local imprints. See also page 73, this issue.

Teaching Nutrition

By PAULINE MURRAH

AS A PUBLIC HEALTH nurse you doubtless call on every resource you know in your community to aid with your work. Your Red Cross chapter may be an untouched ally which you should know more about. To that end, I invite you to consider with me the nutrition education program carried in many of our 411 chapters in the 9 northeastern states from Maine to Delaware. You may be more familiar with the other health services: nursing, first aid, water safety, accident prevention, and blood donor service.

Classes are one method which has always been used in our adult education programs. Nutrition Service is no exception. Let us give you examples taken right from the monthly reports.

CHAPTERS MEET VARIED INTERESTS

"Feed Them Well at Today's Food Prices" is the title which the Hoboken, New Jersey, Chapter advertised when announcing a class for homemakers. Good buying practices in the face of high prices, conservation rules, health needs and the family's food preferences came up for discussion by the group and the instructor.

Two or three chapters have taught groups of patients in hospitals. "Relax in bed and learn" was the idea. Central Chapter of Queens, New York, graduated three classes of women patients. Two classes were given to women patients in wards where the doctors felt the women could enjoy and benefit by instruction. Adequate, normal diets were the basis of the lessons; managing to get the needed food when they returned home came up for discussion. When word got around about the fun these two classes had, the semi-private patients asked for a course. The Rochester, New York, Chapter was the first to report a hospital nutrition class. Back in January 1946 it started one for the ambulatory patients of a tuberculosis sanatorium. By means of a cart which carried an electric plate and other equipment, food demonstrations were given by chapter nutritionists. Paper plates and spoons were used at tasting time.

A "Jerry Class" opened a new field. It seems that a friend of the chapter's nutrition director from the state old age assistance office of Massachusetts said one day, "Why not teach our elderly men and women to select better food on their limited allowances?" And so the nutrition director of the Boston-Metropolitan Chapter decided to offer them a class. Did they respond? The registration was so large that two groups instead of one resulted, with men in one class, and men and women in the other. They learned to choose good, simple low-cost meals which could be prepared on one-burner plates. (A hint to any reader not in the medical world. Geriatrics is the science of caring for the old—hence, *Jerry Class.*)

Men made up one group especially organized for them. The New York Chapter had a shining new nutrition teaching center and Lew Lehr, the noted newsreel commentator generously assisted at the opening by giving an excellent food demonstration. He proved to be a good cook, and the class ate the delicious kidney pie with genuine relish. The publicity about this brought requests for instruction from 75 men. The chapter responded and taught every man whose enthusiasm lasted until his name was reached on the waiting list. And maybe you think that the feminine instructors did not practice in advance so that they could answer the searching questions of these male seekers after skills and knowledge. There were lawyers, newspaper man, dentists, business men, clerks, and actors in the classes. Secretly, I believe the teachers were glad to go back to their women groups where skills were more taken for granted and not probed into quite so thoroughly by the "students." We recommend male classes, however, for men are thorough workers, keep an in-

Miss Murrah is director of Nutrition Service in the North Atlantic Area of the American National Red Cross.

structor on her toes, are fun to teach because they want to learn straight nutrition facts as well as how to cook.

Each class is different. There are the business girls' groups, such as the career girls, offered a class by the Brooklyn Chapter. In this 6-lesson course entitled "The Business Girl's Special," those busy people learned how to whip up a dinner de luxe in just 60 minutes. Someone said that with that ability their social life would be a busy one—and a healthier one, too, no doubt.

Boys and girls of the Scout and Camp-Fire age usually like to join a food class. All over the area in almost half the chapters, the girls of intermediate age, between 10 and 14, come with their leaders to 6-lesson classes and receive a good background for their homemaking activities. Some of the things they do in the foods class are credited as activities by their leaders towards nutrition, foods, cook, and hostess badges. Senior scouts and leaders, too, often have Red Cross nutrition courses. A committee member of the Chemung County Chapter with headquarters at Elmira, New York, planned to teach her packs of cub boy scouts the 6-lesson nutrition course. Outdoor cookery can fit into both the Red Cross class lessons and the activities of the cubs. The director of Nutrition Service at the New London, Connecticut, Chapter had a group of Negro boys from one of the settlement houses who formed a Red Cross chef's club and learned how to plan good meals and cook them.

Brides are happily always with us, but right after the war was over, you will recall, we had a great influx of war brides. They were, of course, the wives of our GI's who had served overseas. The chapter's social service department, or Home Service, helped them in many ways to get adjusted to new communities. Nutrition Service had the pleasure of inviting these new and strange citizens to come and learn something about American food habits and cookery. They were fascinated with our refrigerators, and kitchen gadgets and part of the course was of necessity how to use and care for such equipment. In Newark, New Jersey, the newspapers ran attractive pictures of some of the war brides and their husbands at a dinner served at the chapter house. Seventeen brides finishing a Red Cross food course showed their ex-GI husbands their new skills in cooking, American style, by serving them a delicious dinner. "Some of the men who had had to roll up their sleeves and introduce their wives to an American kitchen gave the organization a rousing vote of thanks," reported the nutrition chairman. Morristown, New Jersey, Chapter had "Supper Club" classes and "Newcomer Teas" for brides.

Two summers ago in 1946 the Newark, New Jersey, Chapter was invited to send a nutrition instructor to teach good food selection to the children at a large playground. The nutritionist and the nutrition chairman decided to work out a plan for learning through games. At the playground, 70 to 100 children took part in recreational activities which were really fun and which featured a food fact. A club of older boys and girls at this same playground met with the nutrition director for more detailed instruction in a series of six lessons. Chapters all over our nine states this last summer developed playground nutrition activities. Rochester, New York, had an extensive program with one nutritionist on the chapter staff showing especial aptitude for working with children and helping them to learn through play.

At Somerville, Massachusetts, the Girl Scouts ran a day camp and their director requested the chapter nutritionist to present a possible nutrition program to them. Such a program could be "stuffy," and antagonize the parents, or it could be well planned and succeed. She reported the activity to us in writing:

> There were certain things which I had to consider: We were dealing with children, not the mother who does the buying and planning of the children's lunches which they bring to the Day Camp. The camp program was recreational with emphasis upon games, handicraft, and so on. The ages of the campers varied from 7 to 14, with the 80 girls divided into 4 units of girls of approximately the same age. While the average period of attendance was two to three weeks, some girls stayed the entire six weeks. The physical plant of the camp was limited. The units met under a tree, a grandstand, a tent, and a field house which had to shelter everyone when it rained. The staff members were a fine lot of volunteers—but untrained professionally. With these limitations in mind we worked out a program. We had a nutrition period during the rest period after lunch, lasting about 15 or 20 minutes on two days of the week. On Wednesday I met with the staff, giving the material and discussing the methods of presentation. In addition I spent some time with the units, supervising improvised food games and leading simple discussions with the girls.

"Personality Charts" were popular with the

older girls at the Somerville Day Camp. The chapter's nutrition director found that just filling out the chart was not enough. "It is surprising how concerned these girls are about their appearance and how they can be attractive." One of the booklets which this original worker used at the Day Camp is "Personality Counts," published by the National Dairy Council. A rating scale sheet accompanies the booklet which includes many suggestions which all of us would approve for maintaining good health.

WHY CLASSES?

Classes are basic to our Red Cross nutrition education program. Reaching groups of people is first of all the most economical use of the professional nutritionist's time and energy. Group instruction offers opportunity to give simple awards to those who successfully accomplish an activity which will benefit both themselves and their families. Red Cross has found from long experience that human beings like recognition in this big world where the individual sometimes gets lost, and longs once in a while to be singled out as a person. And so a certificate is awarded to each one who attends at least five of the six sessions and has carried his part of the lessons successfully. Those who complete the 10-lesson course are eligible to become nutrition aides and wear the powder blue uniform and a nutrition aide pin, as they give their 30 hours of volunteer service to aid the chapter's Nutrition Service committee. These nutrition aides help a professional instructor with her classes by taking the attendance, preparing the room, even perhaps assisting with the demonstration. This is a place our own area Nutrition Service staff and the chapters need to plan more effectively. We should give these thousands who have had nutrition classes something to do which will help them to apply what they have learned and to pass on to neighbors and family the interesting and exciting scientific facts and practical suggestions for improving home life which they have had the privilege of learning.

There is a word I want to say here about adapting the teaching and even the materials to the individuals in the class. Red Cross supplies a kit, which includes course outlines, to each person whom Nutrition Service authorizes to teach a Red Cross nutrition course. It is not our intention, however, to ask that instructor to keep rigidly to the outlines. The basic facts governing good food selection are the same, whatever the approach. Some people can take more of the scientific jargon than others. I have personally taught classes where the women told me frankly the course was being given on too simple a level; they wanted to know all about vitamins, about proteins, and even their component amino acids.

Most of the groups, however, want nutrition in simpler terms. Witness the growing popularity of our 6-lesson course which is taught almost entirely from the point of view of the essential foods, and a simple cooking demonstration is included in five of the six lessons. You may say, "Oh, that is because they want a shorter course than the ten-lesson one." This is doubtless true as they register. It is a fact, however, that many of them by the fourth session are begging the teacher to continue. Chapters are faced all the time with the problem of "advanced courses" for old-timers. Shall they try to reach more "firsts," or shall they encourage chapters to give the interested people more, as they request?

We health educators say over and over that our job is to interpret scientific facts about food and nutrition in terms of income, nationality and religious customs, and family preferences. First, however, we must catch our audience. People are busy and also somewhat indifferent to health, or perhaps I had best say to health habits as such. When we try to attract them to learn about health, we must have titles which will indicate that here is information which will be helpful to have and fun to hear about. Red Cross which specializes in group instruction, therefore, makes quite a point of arousing interest enough to bring registration for a course. Good titles for the course are one way. Here are some examples of titles which capitalized on local or seasonal interest: Adventures in Food, American Cookery Course, Chef's Club for Boys, Food for Health in Later Life, Food for Two, Young Mother's Club, Jerry Class, Food for Fun, Thrifty Food Buying, and Food and Health.

A simple promotion leaflet, "Feed 'Em Well," available on request, outlines the two principal Red Cross nutrition courses offered by chapters in our area,—the Streamlined 12-Hour Course and the somewhat more difficult Standard 20-Hour Course.

VOLUNTEERS ARE ESSENTIAL

Important, however, as food classes are in our Red Cross nutrition program, it is not always possible nor even sensible to organize a class and give a series of lessons. Furthermore, many a volunteer chairman will undertake to arrange a single talk for a women's club or PTA, or put an exhibit in a store window to stress good food selection when she would not feel ready to recruit a class or find an instructor. Remember, that the essence of Red Cross is volunteer service.

This agency offers people of almost any profession, of each sex, of every race, creed, color, and age an opportunity to give service to their own community and also to the nation. The professional staff of the national organization, which includes the five area offices, and of the chapters are there only as guides for the volunteers so that the work may be of acceptable and safeguarded standards. Even the professional and paid staff have the volunteer spirit as is common indeed among workers of any social agency. What one of the professionals does not work the hours it takes to get the job done, rather than the number listed in the book!

Instructors teaching Red Cross nutrition courses are sometimes paid. Many more are entirely volunteer. Socially, it seems sound to me for an agency to offer part-time employment to the person who has had long and expensive professional training, has much to give to society, but cannot even consider a full-time professional job because of her primary family obligations. The Red Cross may make it possible through a modest stipend to employ a "sitter" to stay with an instructor's children for a few hours, or provide the registration fee for a play school.

We also consider it socially sound to pay some instructors and allow others to serve without fee. Each is giving far more than we could pay for anyway, if the class is well taught, and if the members learn and enjoy the process. We are always looking for the woman who has had foods and nutrition as a major in her college course so that we may invite her to become a Red Cross nutrition instructor. We hope that many will come to each chapter and offer to serve, and not wait for the chapter to find them. If one of my readers happens to be trained in nutrition and would like to teach a nutrition class for Red Cross, I hope that she will go or write immediately to her home chapter and offer her services.

OTHER WAYS OF TEACHING

I started a few paragraphs back to tell you of some of the other methods chapters have found to bring food facts before people. Not much space will be devoted to this because all of you in the health education field already know well the old reliable devices which we all employ.

Individual consultations are one way. Sometimes a person learns very quickly when the explanation is given around his own problem. Some chapter nutritionists serve on a loan basis in the local health department or hospital clinics. They become members of the staff and teach mothers individually as they bring their young children to the clinic physicians. An exhibit of the less costly varieties of foods which the doctor has ordered may make the teaching clearer. At the Framingham, Massachusetts, Chapter the nutrition director gives considerable time to the health department's preschool clinics at the request of the health commissioner. The Oranges-Maplewood, New Jersey, Chapter nutritionist serves in the hospital's maternity clinics, teaching each mother referred by the clinic physicians. In a hospital in Montclair, New Jersey, a Red Cross nutritionist served as the teaching dietitian in the out-patient clinic for about five years on a demonstration basis. When the hospital saw its way clear to employ a therapeutic dietitian whose program would include the clinic teaching, the Red Cross considered the demonstration successful and closed.

In Portland, Maine, the chapter nutritionist serves not only maternity clinics on a demonstration basis, but also one or two dental clinics. The nutritionist at the Wellesley, Massachusetts, Chapter is also on the city health department staff. Her constructive program in the schools has shown good results in food choices in the cafeterias.

Last September, the nutrition director of the Oranges-Maplewood, New Jersey, Chapter began regular work with a day nursery. Her objective in setting up this service was to work with the teacher in the nursery to integrate nutrition education into the teaching program. They can work together to experi-

ment with methods and materials. Once they have found acceptable methods, the teacher will go on alone. The social worker of the nursery asked for the service from Red Cross. It could as well have been the nurse, for often she is the one who sees the need. In addition to the educational program in this nursery, the nutritionist has been asked to check menus and suggest short-cuts for the budgets in these days of mounting costs and static budgets. She is also taking part in the activities of the mothers' club. The same nutrition director, as well as her predecessors, has served the visiting nurse association as a nutrition consultant. She holds group discussions with the staff nurses and individual conferences with any nurse who wants to talk over a specific family's problem.

Breakfast campaigns and single talks to club groups, such as men's service clubs, are effective ways the chapters have employed to tell the public about food and health. Radio is, of course, one of the finest ways to instruct, but the script must be well done and the voice compelling and attractive. The Buffalo, New York, Chapter wrote us of their radio talk entitled, "Today's Food and Tomorrow's Health." We like the title. We feel sure you can borrow it freely without credit if you would care to.

CHAPTER SERVICES HELP EACH OTHER

Chapter nutrition committees not only have the other health services, that is, home nursing, first aid, water safety, and accident prevention to cooperate with and serve, but are fortunate in also having as one of the most important services in the chapter a social service department, or "Home Service." Budget allowance schedules are essential to guide those who grant veterans' families money to live on until their government pensions come through or disability claims are settled.

The phrase "cost of living" must have taken on a new meaning to the budget directors of our public health and social agencies. They prepare budgets a year in advance for their organizations. Commodity costs may dislocate these budgets. They can plan better how to meet the need when they are kept informed of current commodity prices. Since food takes about one half of a modest income, it is the most important single budget item. Then, too, as we all know, it is only fair to the family for the allowances to be based on realistic market prices. The Red Cross in a few communities has taken the initiative in organizing budget councils to collect food prices regularly and revise the budget schedules accordingly. These budget guides are then made available to each member agency of the council.

Browse-corners have been set up by cooperative librarians, sometimes at the suggestion of the chapter. A few find that a reference shelf for the instructors with samples of all the teaching materials and one also for the class members serves them well.

NUTRITION SERVICE WENT TO THE FAIR

This year our North Atlantic Area chapters in Maine and New York ventured into a new field for them. The area nutrition field representatives aided the chapter at Bangor to exhibit at the famous Farm and Home Week of Maine. The Wheel of Fortune nutrition exhibit which promotes good luncheons went to several state and county fairs. Chautauqua, Middletown, Albion, Delhi, Madison County, and Walton Chapters in New York State, and Presque Isle, Bangor, Skowhegan and Augusta Chapters in Maine sponsored the nutrition service booths at their fairs. The "Wheel of Fortune" was popular. The top wheel or disc turns to various numbers which correspond to those on trays set with good and poor luncheons. There is also a jingle rhyme scoring the luncheon. If you would like to make a wheel-of-fortune, we shall be glad to send you the directions which appeared in our publication, "Say It With Displays," the Spring 1947 Number.

Another piece of material which you might like to have is the nutrition quiz, "What's Your Answer?" If so, let us hear from you, and we can see that you have one.

TODAY'S NUTRITION SERVICE

Since 1942 a total of 107,552 persons have completed Red Cross nutrition courses in this nine-state area. All of these classes were taught by authorized Red Cross instructors. "Authorization" means that she or he holds a degree from an accredited college with a major in foods and nutrition, or has had an equivalent in graduate work. In addition she has taught at least one year in school, hospital or community agency, and has kept up-to-date

by studying or working professionally within the past four years. Professional training insures that in no Red Cross class will diet faddism be taught, but only sound, simple food and nutrition facts applied to everyday conditions.

In our area in the one year, 1946-47, authorization cards were granted to 863 different individuals. Those who wish to be and have taught reasonably successfully are reauthorized each year. It is with a deep sense of gratitude to all other agencies that we state that the majority of these instructors are affiliated with other organizations, such as hospitals, schools, newspapers, public utility companies, trade associations, and commercial food houses. A smaller number are homemakers with professional training, and we here express appreciation for the generosity of husbands and families for loaning them to us.

CONCLUSION

"The science of nutrition is the science of food and its relation to life and health," states Charles G. King, scientific director of the Nutrition Foundation. Wilson Jameson, chief medical officer of England's Ministries of Health and Education, writes, "Though much fundamental research still remains to be done, we now know enough to enable us to say how various population groups should be fed if health is to be maintained and, indeed, made more robust. This is of the first importance, for good nutrition easily heads the list of objectives in a public health program." Thus nutrition is an important new field for you and me as public health workers.

All of the five area or regional offices of the American National Red Cross have nutrition directors. Each has a staff which includes field representatives who assist chapters to organize nutrition services. In the North Atlantic Area, some 300 of the 411 chapters in the 9 northeastern states have nutrition chairmen, and 26 chapters employ one or more professional nutritionists. A Red Cross nutritionist may be loaned to another agency for a limited demonstration period. Red Cross seeks to work with other agencies in a community health education program intended for all the people.

GIVE TO THE RED CROSS

MARCH WILL BE Red Cross month. President Truman has said, "Many times a year people turn to the Red Cross . . . once a year the Red Cross turns to the people."

Do you know Red Cross services? Peacetime Red Cross services often are as dramatic as those of wartime. . . . Disaster, for example, strikes many communities every year, and it is the responsibility of the Red Cross to coordinate the sympathies and resources of the whole country at such times. In 1947 the Texas City disaster and the September hurricane together required $8,700,000. . . . Red Cross Gray Ladies, Arts and Skills instructors, nurse's aides, canteen workers, and hospital aides are making the hours of confinement more bearable for the men in occupation armies and for the ill and maimed in veterans hospitals. . . . Red Cross activities also include motor transportation in emergencies and widespread projects for children and youth through Junior Red Cross and college units. . . . Red Cross is still the emergency communications link between servicemen and families. It handles financial assistance for veterans and their dependents. It acts for veterans in prosecution of claims for government benefits. . . . Red Cross offers educational services in the fields of health, accident, illness,—first aid, water safety, accident prevention, home nursing, and nutrition classes. . . . The National Blood Program in time will serve the needs of every community for whole blood and its derivatives.

Remember to give to the Red Cross.

Life With Grandfather

By DOROTHY LUNDGREN, R.N.

FOR THE PAST year and a half I have been caring for my grandfather, an old man of 92. I have found a problem or two which have not been discussed in articles which I have read. I thought that if I related my experience it might help other public health nurses to understand what the family goes through in caring for the older citizen of the community.

My grandfather has always been an active person in the town. He organized the local Grange and has been assessor and first selectman. When he became acutely ill, he was taken to the hospital, where he remained five weeks, recovering from pneumonia and a cystotomy operation. He came home with a retention catheter and a happy heart to think that he had survived the hospital at the age of 91. His heart, lungs, eyesight, hearing, and mind are very good. He reads newspapers and takes an interest in current events. He is also consulted by members of the town on matters of boundaries and old roads, because of his excellent memory.

He lives in three rooms of the house. He has his own bathroom, a bed-all-purpose-room, and a corner of the kitchen. His care consists of daily bladder irrigations, enemas about twice a week, dressings changed every other day, medication, and his weekly bath.

With two children and nine rooms to care for I am kept quite busy. I do all the washing, ironing, canning, and sewing. Therefore I have very little time to cater to any patient. However my grandfather seems to be happy here. The children bother him some and he doesn't tolerate certain "goings on," but all things considered I believe he would rather be here than in an institution.

My major problem is cleanliness. This patient with a serious cystitis will not wash his hands after using the bathroom and will go directly from the bathroom to the refrigerator! He puts his dishes in his lap. Therefore I keep all of his dishes separated from those of the rest of the family and boil them. He has his own tray, his own packages of crackers, cereal, sugar, and similar items. Otherwise he would get into the family food and I object to that! One day he insisted upon putting cyanide in a woodchuck hole (we live in the country). He got it on his hands but he wouldn't wash them, saying "They're good enough!" He has a shelf in the refrigerator on which I keep his soda, milk, and whatever else he is using. He gets it whenever he wants it. He doesn't always respect the rest of the refrigerator. I have to put my food and equipment out of his reach and I also have to be one jump ahead of him and anticipate his wants. I have had to teach the children not to accept any food which he offers. They see some of the things he does and understand what I mean. Now they will ask me if what they want is ours or Grandpa's. They respect him and are as good as children can be but they have to be reminded many times to be more quiet. They have their own playroom upstairs which is a blessing.

He takes his own bath once a week and does not do a good job. However, I have to let that pass in order to keep peace. He has very definite ideas of his own which are not to be changed. Before I took care of him I think he took a semi-annual bath although he changed his clothes every week. So I have made some progress. I have come to the conclusion that it is impossible to educate an older person to accept new standards of cleanliness, especially one who has all of his faculties and never was very fastidious!

Every nurse probably has had the experience of having the patient tell the doctor something that she was not aware of and which makes her feel very small. Because I am a granddaughter I haven't "had the ex-

Mrs. Lundgren was doing public health nursing in Clinton, Connecticut, until two years ago when she left her job to take care of grandfather.

perience that a person 92 has had" and I really "don't know very much" and I am usually trying "to put something over on him." Another argument is that "things aren't done as they were in the old days." In order to get the cooperation of my patient I have to ask the doctor to tell him how much he is to drink, how many times a day he must have the irrigations, and just how much medication he is to take. Medicine is "no good" unless it is a syrup of dark color. If after a day or two of consuming a certain medicine he can't see any change, he "doesn't want any more." He reads about something in the paper that is good for the kidneys and he wants to try it. One day he found a concoction in an old piece of paper and insisted that I try to get some. The druggist had never heard of part of it! He asks for sleeping pills and then says they are only "bread dough," yet he sleeps an average of 12 to 16 hours a day!

I have to put up with these things but usually I am successful in getting him to do what is necessary after careful explanation. His doctor is very understanding and helps me all he can. He usually comes when he has time enough, to explain and convince the patient to cooperate. I try to let him know in advance when he is needed so that he can arrange to come when he has the most time to spend with the patient.

Grandfather's diet is another problem in itself. He likes few vegetables. He is fussy about his food, eats little, drinks only about a quart a day, and has to have soft food because he has only four of his own teeth and no false ones. I try to make his tray attractive and give him what he likes. I offer him adequate liquid but if he doesn't want it, he pours it out.

When he is hurt by his treatment he fights it and says he doesn't want to live. He must be reasoned with, cajoled, and encouraged.

There is no question a patient in the older age group is a very special responsibility. Someone must be with him or within call at all times. Usually he is domineering and independent, yet he must be helped to accept opinions, advice, and help from other members of the family. Children must be taught to respect him and to understand his incapacitation. All the family must remember the old person is often lonely and frightened. Also he needs something to do in order to keep his hands and thoughts occupied.

It would help families greatly if someone outside the home—another relative, a friend, or even a paid helper—would visit fairly regularly to sit with the patient for an hour or so. It would be a lift to family morale if there were times when all the members of the family could be relieved, even for short periods, from the care of the older patient. In addition, the visitor would bring into the sickroom a fresh point of view and new encouragement.

After having taken care of my grandfather in my own home for the last year or so I feel infinitely better prepared to take care of other old people. What I have learned has been not so much technics and other professional matters as a broadened point of view toward the special needs of all old people and particularly old people who are ill, and also the special understanding which the well members of the family must give to such a person.

New Poster—"GOING MY WAY?"

A public health nurse striding along "The Way to Better Health" graces the new poster for public health nursing. The slogan is "Going my way?" It is printed in two colors, green and navy blue, and the size is 16 by 20 inches. Prices are as follows:

On 5-ply cardboard with imprint "National Public Health Nursing Week, April 11 to 17, 1948." Price for each carton of posters (12 per carton), $3.50. Each additional poster not in a group of 12—price 35 cents.

On 5-ply cardboard without any imprint referring to the "Week" but with space for local imprint. Price same as above.

On coated paper without imprint referring to the "Week" but with space for local imprint. Any quantity can be ordered. Each poster 25 cents.

Send order to NOPHN, 1790 Broadway, New York, with payment in order to avoid extra costs of billing. If sent by first-class mail charges are slightly more.

Public Health Nursing in the Cancer Control Program of the U. S. Public Health Service

By ROSALIE I. PETERSON, R.N.

THE nation's concern over the problem of cancer is evidenced by the articles in the press, by comments and discussions on the radio, by congressional appropriations, and by voluntary fund raising campaigns for cancer control purposes.

In 1937 Congress enacted a bill creating the National Cancer Institute for the purpose of cancer research and control. A specific appropriation of 2,500,000 dollars was made available in 1946-1947 to states for grants-in-aid for the state cancer control programs.

In 1947-1948 this appropriation was increased, and over 5,500,000 dollars was set aside for these programs, of which 3,500,000 dollars was allocated to states to assist them in establishing full-time, balanced, cancer control programs. The following conditions are considered in allocating the funds to states: (1) the extent of the cancer problem in the state; (2) financial need of the state; (3) population within the state and (4) population density of the state. This money, which is given to the state, may be used by the state health agency to direct or operate cancer control programs, to pay for services to cancer patients, or for reallocation to other agencies within the state to conduct cancer control activities.

Funds are also available for grants to states for special projects dealing with special phases of the overall cancer program, which some organization within the state may be able to perform alone or in cooperation with the state health agency.

Other features of the grants-in-aid are (1) the loan of trained Service officers upon request to states to organize, operate, and direct the program and (2) the offer of consultation service on cancer to states from the district offices of the U. S. Public Health Service.

In addition to the grants-in-aid portion of the program, studies will be conducted to determine the extent of the problem and to extend current knowledge in all phases of cancer to professional groups.

The objectives of the nursing activities in the overall cancer control program are (1) to prepare nurses to help combat cancer by extending the knowledge of the disease to all nurses (2) to stimulate better case-finding methods (3) to assist in reducing the time between the onset of symptoms and reporting for medical treatment (4) to help states to develop an adequate follow-up system on cancer patients and (5) to improve nursing care to cancer patients.

Most nurses feel that we have a limited knowledge of cancer and of the care of cancer patients. Cancer was not taught as an entity but was found in all services and in all age groups. Consequently we have to think back to individual cases when we think of cancer. We are still confronted with the same problem, since cancer does affect all age groups and is found in all services. To help us focus our attention on the problem of cancer, we visualize the following program for the coming year.

To assist in establishing postgraduate courses in cancer nursing, we hope that the committee working on the prerequisites for advanced curriculums will be ready to make recommendations for all advanced courses before we outline the contents for the specialty in cancer nursing. In the meantime, we have had a preliminary meeting with one of the universities and will work closely with its staff. As the prerequisites for the advanced

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courses are not known as yet, some time may elapse before such a program can be developed and the teaching staffs prepared.

MONEY HAS been allotted to states for the cancer control programs and plans for their programs are being made. It is, therefore, essential that some assistance be made available to state directors of public health nursing so that they can give assistance to their cancer control directors in the development of the cancer programs. To meet this need, the Public Health Service has arranged two institutes, each of a month's duration, for its district public health nursing consultants. This program has consisted of two weeks of lectures and observations in the Roswell Park Memorial Hospital, Buffalo, N. Y. (New York State Cancer Hospital); one week in New York City, which included observations at the Strang Clinic, Memorial Hospital, Nassau County Health Department (where the public health nurses have integrated cancer in the generalized program), and the American Cancer Society; and a final week with observations and lectures at the tumor clinic at the U. S. Marine Hospital, Baltimore, which is one of the largest and best equipped tumor clinics in this country, and at the National Cancer Institute at the National Institute of Health. The district nursing consultants are, therefore, now in a position to give assistance to state directors of public health nursing in conducting institutes for public health nurses, in developing staff education, and in program planning in cancer nursing.

Concomitantly with this program plans are being made to develop a short course (2 or possibly 3 weeks' duration) to be given for university teaching personnel, consultants, and supervisory nurses in states and in the larger volunteer nursing associations and local health departments. This course will consist of lectures including medical and nursing aspects on the various sites of cancer, such as head and neck, respiratory tract, digestive tract, rectum, breast, female and male genital organs and hormonal therapy, genitourinary tract, and bone; on mental hygiene, and nutrition. Interspersed with the lectures will be slides and movies (which have been secured by our own agency and jointly with the American Cancer Society and other private agencies and institutions) showing cancer in the various sites in earlier and later stages, and illustrating the nursing care to patients.

We shall also assemble data on the common types of metastases as to place, length of time of development, what type of treatment can be given when it occurs, how long the patient will be a bed patient, and what types of nursing service will be needed.

Although our first emphasis on extending knowledge in cancer will be directed to the teaching, consultative, and supervisory personnel, plans are under way to develop material for the students in the basic public health nursing program of study and for basic nursing schools.

THE PREPARATION of nurses already in the field and of prospective public health nurses is essential before the other objectives of our program can be reached. To do better case finding and to reduce delays in reporting for treatment, the peculiarities of cancer must be understood by the nurse. Cancer is a disorderly growth of cells, which serves no useful purpose; one may have this multiplication of cells in any part of the body. Many observations have been made, and many data have been collected on peculiarities due to site, age, race, and sex. Most of us have seen cancer of the skin, as 75 to 80 percent occurs on the face. This is a common type of cancer but it is not highly malignant, and under proper treatment 90 to 95 percent of these cases can be cured. There is more cancer of the skin in the South among the whites than the Negroes. This may be due to the fact that the solar rays, which are known to be carcinogenic, are filtered by the dark skin. Cancer of the skin is also more prevalent among people such as sailors and farmers, who are exposed to the elements. It begins as a small sore which is usually nonpainful but continues to enlarge. Nurses should always observe scar tissue, especially from burns, and look for beginning small nodules.

Cancer of the uterine cervix is more common among women who have borne children, but the incidence of cancer of the body of the uterus is higher among women who have never been pregnant.*

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*Levin, Morton L. The epidemiology of cancer. *American Journal of Public Health,* June 1944, v.34, p. 611-620.

Studies have shown that the incidence of breast cancer is appreciably higher in women who have no children.*

Nurses should also be familiar with the results of various types of animal research. For example, a special research study is being made on the role of the milk factor in the etiology of breast cancer in mice. Mice which have been inbred for generations through brother-and-sister matings and are essentially pure stock were observed in a breast cancer study. Certain strains of mice are more likely to develop cancer of the breast, and it was observed that if the new-born mice of a breast-cancer strain were permitted to suckle, even for only a few minutes, they would develop breast cancer at a later date. If the new-born of a mother of a high-breast-cancer strain were not allowed to suckle their own mother the incidence would be no higher than in a low-cancer strain. Whether this can apply to the human being is not known today. From a hereditary standpoint, it may be a significant factor, especially if further studies show that it applies to human beings.

In order to decide intelligently on proper follow-up and bedside nursing care, studies need to be conducted. We need to know what the average cancer case load is in a generalized public health nursing program, what type of service is needed and by whom it should be given, the trained public health nursing nurse, the graduate nurse, or the practical nurse. The Public Health Service hopes to do such studies in cooperation with many agencies where a bedside nursing program for cancer patients is under consideration or is already being carried out.

To help states with their in-service staff education program, especially where cancer is receiving special emphasis and full-time service is needed, the Public Health Service has given a special orientation in cancer to a small group of public health nursing consultants, who may be assigned to states upon request. These nurses will be on loan for approximately one year at a time.

THOSE OF us who are older public health nurses, whenever we think of the cancer patient, will probably call to mind the extremely ill patients such as we cared for as student nurses. Their suffering was probably the most excruciating endured by any patient. We may also think of the odors that made it so repulsive to be with the patient. If that is your mental picture of cancer patients, I hope that you will have an opportunity to visit a hospital today where such patients are looked after. It is almost revolutionary in its change. One seldom sees the patient who is suffering the excruciating pain that was common in the earlier days. In fact very little morphine is given to patients. Palliative surgery is now done, regardless of the age of patients. Persons who are in the 80's have such radical surgery as complete gastrectomy, whole lungs are removed, rectums are removed, radical surgery on the face is done, and new faces are fashioned. In most hospitals where such radical surgery is done, the patients are given highly concentrated diets with huge amounts of vitamins. Plasma is given prior to surgery, and whole blood and plasma are given following surgery. In a remarkably few days these patients are up and about. At an early period, patients are taught to take care of themselves. Colostomy patients, for example, are taught to take an enema, sometimes daily and sometimes every other day, and very often the body regulates itself to having a normal bowel movement once daily. Colostomy dressings in some institutions consist only of paper tissues worn under a two-way stretch garment. When stomachs are removed, the intestines soon modify their function and assume those of the stomach also, and in a remarkably short time the patients get along on three meals a day. Patients who have had tracheotomies are taught to rinse the inner tube as frequently as needed for cleansing purposes and in some institutions are taught to remove the outer tube also. Patients who have had radical facial surgery have new noses, new ears, and new faces built either by plastic surgery or by prosthesis in our hospitals today.

However even more important are some of the methods of early diagnosis that are being developed. Some of you have already heard of, and all of you will soon know of the Papanicolaou test, or, as the test will soon be called, CTC (cytologic test for cancer). This test is a simple smear which may be obtained from excretions from the cervix and body of the uterus or may be made from fluids or

* Levin, Morton L. *Op. Cit.*

aspirated materials from other parts of the body, spread on a microscopic slide and properly fixed and sent to a laboratory for a special staining, the Papanicolaou stain. This stain shows cells which have undergone nuclear change. Although it takes trained pathologists or technicians to make the stain and to read the slides, the family physician is able to make the smear in his office when the patient reports for examination, and he then mails the slide to a laboratory for a report. Think what this will mean in early detection of cancer, especially of the genital tract! This test is regarded as a screening method and should be followed by biopsy procedures. In a number of cases, a persistent positive cytologic test has been reported with a repeated negative biopsy. Exploratory operations have been made in such cases which have usually revealed the presence of a malignant tumor. This same test has been applied to bronchial secretions from the lungs, to urine, and to stomach washings. It was told that in a patient with a persistent frontal headache a CTC was made from a discharge from the nose which revealed cancer cells with the Papanicolaou technic. On the basis of this, an operation was performed, and cancer of the ethmoid was found.

OUR RESEARCH workers feel that there is no one cause of cancer. They also believe that the solution may be found through chemistry. Possibly all people may have the potentiality to form a neoplastic growth of cells; possibly such a growth occurs more frequently in some families than in others. No one knows today, nor does anyone know why all of a sudden the cells form this disorderly growth. It would seem that with the CTC and with the result of the many years of research, we must be near a solution. You and I are taking part in this study and in so far as we use our knowledge and are ever on the alert for new discoveries which may apply to nursing, we may do a great deal in helping to advance the day when a much larger percentage of the people who are now ill may recover, and many other potential patients may remain well. Today, early detection is the only method of reducing the death rate from cancer. We are on the front line.

Presented before the Seventy-fifth Annual Meeting of the American Public Health Association in Atlantic City, N. J., October 7, 1947. This paper appears also in the *American Journal of Public Health* for February.

HONOR WHERE HONOR IS DUE

The following letter was written by an eighth-grade pupil on the occasion of Public Health Nursing Week:

New York

Sister Miriam Monica

Dear Sister,

This letter concerns the exceptional work of the Public Health Nurse, who is in reality an "Angel of Mercy." Another title that could readily be applied to her is "Johnny on the Spot." By this I mean she is always where there is sickness or trouble.

Her solicitude in children is unending; for example, in the schools, she is forever guarding the health of the pupils.

Where there is a new-born baby and the mother is finding difficulty in managing the house or in any other way, the Public Health Nurse is always present, ever willing to offer service and advice.

She works in the hospitals, as well, always kind and thoughtful, working for very low wages, if any.

As we all know, we are threatened with a smallpox epidemic. Without the aid of the Public Health Nurse the spread of this dreaded disease would probably have attained greater heights. Clinics, hospitals, and health centers are all opened twenty-four hours a day to check this disease. And yet even a greater service is being performed by the Public Health Nurses. In lower Manhattan there are sections where the majority of people do not speak English. Nurses are stationed there, explaining to the people in their native tongue and vaccinating them.

Only one week in the whole year is set aside to honor these wonderful women, who work unselfishly all year. Although they have only this meager time assigned to them, let us never forget how vitally important they are at all times.

So, you see Sister, the Public Health Nurse is a very valuable and outstanding figure, not only in our own community, but all over the United States.

Respectfully yours,
KAY WENTON

The Cancer Patient as a Person

His Needs and Problems

By ELEANOR E. COCKERILL

THE SUCCESS of any method of prevention or treatment of cancer depends in the last analysis on the patient's own participation in the plan. The development of cancer is one of the emergencies of life which puts to a real test the total resources of the individual. What a particular individual does about this threat to life and security is usually characteristic of the manner in which he has met other crises. The following excerpt from an interview of a medical social worker with Mrs. F. shows her to be a woman of prompt action, who has probably dealt directly and responsibly with previous life experiences which she has regarded threatening to her well being:

Patient is a stout, red-faced woman with a friendly, straightforward manner. She is sitting on the side of her bed as worker approaches. Worker introduces herself as the social worker on the surgical ward and explains that she is interested in knowing how patient is getting along. Patient accepts this introduction and replies that she is feeling just fine. She inquires whether worker knows that her operation has been postponed. Worker acknowledges that she does and Mrs. F. explains further that it had been scheduled for this morning but the doctors had wanted to test the blood of members of her family in case a blood transfusion should be required. Worker inquires how patient feels about this delay in her operation. Mrs. F. says she is really sorry that they could not go ahead this morning, as she feels that even a few days may make some difference in her condition. That is the reason she came to the clinic as soon as she was aware that she had a tumor. Patient describes her horror when she first discovered it. She woke up one morning and the moment she touched it she knew it was cancer. She attempted unsuccessfully to waken her husband and when she could not she hurriedly dressed and ran to the home of her married daughter who lives in the next block. Her daughter had also been much alarmed and had told her to go to the clinic immediately. She had gone the following day.

Mr. S., a 65-year-old single man, responded in quite a different manner to the knowledge that he had a tumor which required immediate surgery. He became frightened when told that he must have an operation and left the clinic without making any of the necessary arrangements. The social worker sent him a letter offering to help him with any problems he had about this recommendation but he did not respond. Finally, his relatives prevailed upon him to return because of his intense suffering and their concern about him. Following is an excerpt from the interview of the medical social worker with Mr. S. at the time of his return to the clinic. In this material we see reflected the intensity of the fear which had kept this patient from utilizing the help extended by his surgeon:

"I was recommended to come to this place on Monday and I've been trying to get here ever since. But I just couldn't until today." The worker inquired, "Can you tell me why you have been so afraid?" Mr. S.'s reply was immediate, "Yes, I know. Afraid I would die in the operation. Afraid I would bleed to death. It's fear that's kept me away." Again the worker inquired, "What helped you to come today?" Mr. S. hesitated for a moment and then replied, "The advice of a good, old honest man. He wanted me to come here but he's against cutting, too. He's been telling me right along I had cancer. Why, when I first heard that I felt just like I was going to be electrocuted." Mr. S. then referred to another old friend who had advised against surgery, "An old friend told me one and a half years ago 'You'll live a long time with that if you don't let them do any cutting.'" Since then, Mr. S. said he had been using "alum water and the like." The worker pointed out that Mr. S. was faced by the necessity to decide between the advice of friends and that of the doctor. Mr. S. nodded in agreement and said, "Yes, that's the question." Then there was another question from the worker, "Whom do you really trust the most?" Mr. S. replied immediately, "The doctor." Then a pause followed and abruptly Mr. S. spoke again, "You wouldn't want me to come right away, would you?" He watched the worker's face as he awaited her reply. She said, "No, we will let you decide that for yourself." Mr. S. relaxed somewhat, then said very decisively, "If I could be treated without cutting, I would be relieved a whole lot." The worker made no comment but waited for Mr. S. to speak again, which he did in a few seconds. "If I would make a start to come Monday or Tuesday, how would that be?" The worker replied, "That

Miss Cockerill is professor of social case work in the School of Social Work of the University of Pittsburgh.

would be all right." Mr. S. continued, "I would come up, say about noontime on Monday or Tuesday." The worker explained that it would be preferable if he came about one-thirty. Again Mr. S. looked at her intently. "What would happen if I shouldn't come at all?" She replied quietly, "We would be sorry." "Why?", he queried again. "Because we want to help you," she said. There was a slight pause and Mr. S. commented, "I really believe you do." After this, the tension seemed less and there was some additional interchange of questions and answers and the interview appeared ended. As Mr. S. made his way to the office door, the worker inquired whether or not they should expect him on Monday. Mr. S. stopped, turned and again looked at the worker as he inquired, "If I don't come on Monday, will you take me off your lists?" To this she replied that he would be kept on the list until he was ready to come. Mr. S. spoke very emphatically, "If it weren't for this cutting business you would be sure I'd be right here on time. As it is, I don't know."

Mr. S. did return for surgery but not until long after it had been initially advised and not until he was forced to do so because of the intensity of his discomfort. Mrs. F., our first patient, became anxious when her operation had to be delayed for a day or so in order that necessary precautions might be taken. These two patients do represent extremes in reaction but I have selected Mrs. F. and Mr. S. because they are illustrative of how two individuals may respond in very different ways to the same threatening experience. Mrs. F. when frightened became mobilized for action. Mr. S., on the other hand, seemed to be paralyzed by fear and unable to act.

We do not have available the knowledge about Mrs. F. and Mr. S. which would enable us to understand the reason for their different reactions. In fact, it is not essential that we have this understanding in order to help these two patients meet the problems related to their illness and need for medical treatment. It is absolutely essential, however, that professional persons—doctors, nurses, social workers—who attempt to help patients like Mrs. F. and Mr. S. have the capacity to perceive individual differences in patients and to be aware of the person, himself, as well as the malignant lesion which threatens his life and well being. If we are able to perceive the "person within the body," as well as what is happening to parts of the body we will be less satisfied with general conclusions concerning the strength and adequacy of a particular individual who is faced with the problems of malignancy.

Let us follow Mrs. F. a little further in her experience with cancer in order to observe her own particular way of meeting this experience. Later in the interview previously quoted, Mrs. F. and the medical social worker discuss her experience more fully:

Patient described her experience in the clinic. After she had been examined by several doctors, Dr. M. had told her that she had a tumor which must be removed immediately. She had asked him if it was a cancer and he had told her that from outward appearances he believed that it was. He had stood behind her when he said this and patient thinks he probably was afraid of how she would react to this diagnosis. Patient went immediately to the admitting office to make arrangements to enter the hospital. When she was told the expense involved, she became much upset and began to cry, as she had no way of meeting this expense. The woman at the admitting desk asked her to wait a few minutes and patient was then told she might enter the hospital on July 13. Patient was so eager to come that she was really "not frightened about entering at all." She has never been sick in her life and has always been a hard worker. She really does not know what it is to be down in bed. The thing that alarms her is that the tumor could have become so large without her having noticed it before. Patient refers to the current campaign against cancer. She has read a good deal about cancer and is impressed with the fact that early cancer can be cured. She has also heard talks over the radio, which she considers quite worth while in the informing of the general public of the need for early treatment. Patient remarks that she has always had a great fear of cancer. She attributes this to an experience which she had as a child. One of their neighbors, an elderly man, had a cancer of the face for months and had to be fed with a tube. It was really "a living death," he was simply eaten away. It seemed to patient as though it were some terrible unseen monster which was devouring his flesh. Patient has always said that if she had a cancer which could not be cured she would commit suicide. In spite of these deep-seated fears, patient is surprised that she does not seem to be really worried about herself. Her only concern is that the doctors may not cut away all of her which is "bad."

She dreads more operations. Worker states that the doctors attempt to remove all of the diseased tissue but that sometimes it is found that the tumor has metastasized or spread further than is evident and that in this event sometimes second operations are necessary. Worker suggests that she ask the doctor for further explanation about this possibility. She tells Mrs. F. of the tumor follow-up clinic which she will be asked to attend after she leaves the hospital. Through this means the doctor can examine her from time to time in order to ascertain the need for further treatment. Patient thinks this is a "good idea" and laughingly remarks that she hopes someone "will get after her" if she does not come into the clinic regularly. When she is feeling well it is so easy for her to neglect herself, but this clinic attendance patient considers most important. Patient says she is really worried about her husband because he is so much concerned over her. He told her

that as soon as the neighbors learned that she had gone to the hospital they had come over and urged him to discourage her from having an operation, believing that it was certain death. This had alarmed Mr. F. but has only tended to anger patient. Patient considers this her own decision and no one else's responsibility. By coming to the hospital she did what she considered the best and no one is going to alter her in this. Patient expresses disgust with people who "talk without knowing." She contrasts this with her discussion with worker whom she feels understands what she is going through and can help her "build up confidence." Patient feels that she must have even more confidence in the hospital because she is coming without money. She had understood that this would, of course, affect the type of medical as well as nursing care which she would receive. Worker attempts to explain to patient that this is not the case at all and that the type of care she will receive will be of the same standard that is given pay patients. Mrs. F. expresses relief about this and says it is something both she and her husband have been worried about.

IN THE writer's opinion, Mrs. F. is representative of a large group of individuals who, though fearful, do have sufficient strength within themselves to face reality and to be responsible in their use of available resources of help if their capacity to do this is recognized by persons in the environment. Mrs. F. was not without fear and anxiety. Many of her comments reflect the impact of this situation upon her. In fact, she was motivated in coming to the clinic by fear; she finds postponement of surgery hard to accept because of the fear that too much time has been lost already; she is fearful about future recurrences and the need for repeated operations. However, Mrs. F. asserts that even though she does have cancer, she is still a functioning person, capable of making her own decisions. She is angry when persons in the environment try to deprive her of this right. At the same time she does recognize that she needs to be helped in this experience and expresses appreciation of what the social worker is doing to "build up my confidence." It is important to note in this interview that the medical social worker offered little that might be considered as reassurance in the usual sense of the word. One would have to conclude, therefore, that Mrs. F. has felt support and respect from the worker. Her comment that the worker "understands what she is going through" implies that she has become more confident in her capacity to go through this experience because the worker does know how difficult it is and yet has seemed to feel that she would be able to do what was demanded from her; that is, she does not attempt to modify the difficult reality that Mrs. F. is trying to face.

Just before Mrs. F.'s operation was performed she was able to discuss her feeling about death with the medical social worker. Again, her philosophy was something very important and individual to her as she looked death in the face. She referred to a sermon which she had recently heard based on the twenty-first Psalm and commented that this text seemed to be meant for her. Sin, she said, can destroy the body but not the soul—her real self. If her illness represented punishment for some sin she had committed she was confident that she "could stand it" and would probably be a "better woman for it." She felt that her illness must be a test which God was giving her and if she was able to recover she would be the stronger for it. She admitted to a belief in predestination and said that when her time came to die she was not afraid. She told her husband that she was not afraid no matter what happened. The worker inquired whether she felt that death might result from the operation. Mrs. F. was then able to talk about her concern about the anesthetic and whether she would ever wake up. In the interview following the operation, Mrs. F. reported that the operation was not nearly as bad as she had anticipated and did not seem as serious as childbirth which patient had also experienced.

It was fortunate that this worker was able to help Mrs. F. in her effort to deal with the possibility that she might not recover. This is a topic which is difficult for even the most secure of us to face. And yet our evasion of this all-important consideration does not necessarily lessen the patient's fear and apprehension. Frequently our own fear leads us to desert the patient when he needs us most. I can still vividly recall some of the panic I felt when patients mentioned the possibility of death, and how much courage it often required from a patient to really help me to face this issue with him. One patient, in an interview on the day of his admission, suddenly inquired, "How do people leave this hospital?" I replied rather lightly that some were able to walk out the front door, others had to have a wheelchair. He was quite irritated and tried again to get the information he wanted. This time he was much more specific. "No,"

he said, "I mean, do people go out head first or feet first?" I said apparently he was thinking that he might not recover. He said that in case he should die there were some arrangements he would want to make. He then explained that he knew the county commissioners would not have enough money to send for his body and he would hate to be buried in the paupers' field in this strange city. If there was any possibility that he might not get well, he would like to get in touch with some friends at home and get them to promise that he would be buried in his home town. The worker pointed out that any surgical procedure had a certain amount of risk and suggested that since this was such an important matter to him, it might be well for him to make these arrangements. This patient did leave the hospital on his own feet and before his discharge he expressed appreciation of the fact that he had been helped to get "that worry off his chest."

Mrs. F. seemed to be saying to her worker that she was going to put all that she had into getting rid of her cancer and although she felt her own strength would make this possible, she was also able to accept the other eventuality. She had expressed her desire to live through doing all that she could to save herself. If she died it would be because a power stronger than herself was in command and for His decision, she was not responsible. That was Mrs. F.'s own individual way of resolving for herself the conflict about death. It is my conviction that it helped her to be able to express her feeling to the social worker who was able to face the possibility of death with her. Often patients cannot discuss this with members of their families. The nurse or social worker may be the person most accessible.

OUR EXPLORATION of some of these differences between individuals and their way of meeting life crises leads to the conclusion that generalizations about the cancer patient as a person are unsound. It is just as unsound to assume that all individuals can deal with the fact of cancer as it is to assume that no individual should be faced with the reality of this diagnosis. Certainly our professional task becomes much easier if we can be guided by rules, since then we are relieved of the responsibility for assessing this uncertain factor.

One young physician decided that from a certain point on he would share this diagnosis with all of his patients, since he had become convinced of their right to have this knowledge. He was a very sincere young person who had come to this decision after a good deal of thoughtful consideration but with also a good deal of personal insecurity about something which he accepted intellectually but not emotionally. Then came the day when his newly established convictions were put to the test. As he was taking a preliminary medical history of an attractive young woman he became more and more sure that his examination would reveal malignancy. He was tense and anxious and avoided looking directly at his patient because he found this difficult. When he had completed his examination of the patient's breast, the young woman inquired "Well, doctor what is it?" Completely absorbed in the task of mobilizing himself for the ordeal, he replied tersely "What do you think it is?" His patient responded "I'm afraid it's a cancer." With averted gaze, the doctor said, "That's what it looks like to me." The patient became hysterical and it was not until then that the doctor became fully aware of her protruding eyeballs and enlarged thyroid, both indicative of possible hyperthyroidism. After this experience, this doctor reversed his opinion and said that he would never tell any patient the truth again, because of the acute anxiety which this knowledge had produced in this young woman. We can all identify with this physician's feeling about this experience and with his desire to avoid future mistakes. One solution is certainly to say, "Never again." Another, more exacting solution, is to pledge oneself anew to the effort to understand more fully the patient with his cancer, to the development of greater capacity to see beyond the lesion to the person whose cancer it is, to be able to view the cancer through the patient's eyes as well as our own.

Miss Thomas came to the Social Service Department after a follow-up examination in the tumor clinic. She was obviously in quite an upset state. She said she believed that she would lose her mind unless someone would tell her the real truth about whether she had cancer or not. The social worker said that her behavior indicated that this must be something that was tremendously important for her right now and asked to be told a little

more about the situation. The patient went on to explain that she was living in the home of a married brother and that the sister-in-law followed her everywhere throughout the house with a bottle of lysol disinfecting everything she touched. Said the patient "If I could be sure this was cancer, then I could tell my sister-in-law that all of that disinfecting is nonsense because I know cancer isn't catching. But if it isn't cancer and I should have something catching, I wouldn't want to live in a house with children and I'd get right out of there." The worker suggested that this patient tell her physician the real reason why she had to know her diagnosis. Although the doctor felt he was running a risk he did assure the patient that she had cancer, not something else which might be catching and her anxiety diminished rapidly. This patient was a practical nurse and several months following this incident she was able to resume her former means of livelihood. She was called to care for a patient in the terminal stages of cancer and the physician in charge was the one who had treated her in the clinic. He expressed surprise about how relatively comfortable Miss Thomas was with the knowledge that she, too, had suffered from the same disease. As the doctor and social worker discussed this together, they concluded that for this particular individual there were dangers which were much more frightening than the possibility of cancer and that, for her, it had meant relief from anxiety to know *what it was she had* so that she would know where she stood in relation to the other diseases she feared more.

FOR SOME INDIVIDUALS cancer does have a very special meaning and is more dangerous and more to be feared than anything else that might overtake them. Sometimes the patient's reaction is almost one of panic. In order to protect himself from this overwhelming anxiety the patient may make use of one of several possible defense mechanisms which are used by all of us when we feel threatened or attacked. Escape through denial that anything is wrong is perhaps the most frequent of these mechanisms. If one can say that the doctor is mistaken about the illness, that there is nothing wrong which cannot be corrected by a change in daily regime or way of living then one is relieved of the responsibility for doing anything about it. The capacity to accept a medical opinion is not necessarily based upon intelligence or knowledge. I remember very well an incident which a prominent surgeon related to me. He was asked to examine the wife of another surgeon who felt that she might have a malignant tumor in her breast. While they were engaged in conversation, the surgeon who was being consulted observed that the other physician was very hoarse. He commented upon this and was told that he had just been smoking too much and had a cold which he couldn't lick. The surgeon said that he was much more concerned about this symptom in the doctor than he was about the possibility that his wife might have cancer. An examination was made and the doctor was found to have an inoperable carcinoma of the larynx. It was later learned that this hoarseness had persisted for a period of six months during which the doctor had refused to believe that the symptom was anything more than a stubborn cold or a throat irritated by too much smoking.

For other individuals, anxiety may be handled through giving the disease another name. This is perhaps the most frequently employed means of defense against fear and it is one to be respected as the patient's own way of handling the situation. The words "tumor," "swelling," "lump," "growth" are those most frequently employed. I have worked with patients who spoke of cancer during certain phases of their care and at other times reverted to a less threatening name for it. It would certainly be unwise to deprive any individual of the right to escape from a painful reality through the use of this means of defense. However, the point often arrives when the patient is ready to move out a little more courageously and deal with reality. In my opinion the doctor, nurse, or social worker can often enable such a patient to do this if they are aware of the patient's readiness to take this step and if they are not afraid to have him do so. We are sometimes afraid that the patient is trying to "trick us" and that if he is given the truth he will go out and commit suicide. Even if this should result, is it not the patient's right to take this way out? My experience offered evidence to the contrary. For many individuals, the impact was pretty great but I had the opportunity more often than not to observe a remarkable degree of stability in the face of what must have been a

powerful blow. I have felt very humble as I have watched these individuals accommodate themselves to the uncertainties which the diagnosis introduced, as I have seen them devote themselves even more fully to the business of living. Some people become stronger in the face of danger, others are overwhelmed by it.

As we come to understand more and more about the nature and cause of cancer and the means for its control, it is my hope that we will also increase our understanding of the individual who has the cancer. If we really believe that the human organism is a unified whole, we cannot afford to underestimate or overestimate the capacity of the "person in the body." No doubt we shall be more aware of the patient himself, when we ourselves master our own fear of his disease or at least are able to separate our feelings from those of the patient. Certainly our attitude toward many other serious diseases has not made us so universally over-protective of the patients who suffer from them. We have felt more confident about what we can do to help and therefore are freer to share reality with the patient. Let us look forward to the same type of relationship with the cancer patient—one in which knowledge and responsibility are shared.

CANCER INSTITUTE

An intensive course in cancer control was given at the University of Washington School of Nursing, Seattle, during the week of November 10, 1947. This course was sponsored by the American Cancer Society, Washington Division, in cooperation with the Washington State Department of Health.

The class was limited to 25 nurses, of whom 13 were public health nurses, 10 were from general hospitals, and 2 were industrial nurses. The nurses were selected from teaching positions in all sections of the state. It was felt that through this group, the agencies and hospitals would also profit from the course. Dr. Stuart Lippincott, professor and executive officer of the Department of Pathology, School of Medicine, University of Washington, did most of the planning for the medical lectures dealing with current research and modern treatment of cancer. Directors of field work in the Division of Hospitals and in Public Health Nursing, together with Grace Watson, E. I. consultant, State Department of Health, planned the nursing sessions. Rosalie Peterson, public health nursing consultant in the Cancer Control Division of USPHS and Alice Rorrison, senior nurse officer, USPHS were in attendance as resource personnel for the nursing aspects of cancer treatment.

The medical lectures, including demonstrations of gross specimens as well as lantern slides, covered the following subjects: concept of neoplasia; cancer research; autopsy and surgical pathology with a demonstration of frozen sections; cancer of the female reproductive system; cytological diagnosis of cancer; cancer of the skin and bone; cancer of the gastrointestinal tract; radiation in the treatment of cancer; neoplastic diseases of the blood-forming organs; statistics in oncology; care of the terminal case; surgeons' approach to cancer diagnosis and treatment; and other groups of neoplasms and the tumor registry.

The nursing sessions which used the facilities of Swedish Hospital, Harborview King County Hospital, and Swedish Tumor Institute covered the following: demonstration of nursing care in cancer of the breast and gastrointestinal tract; panel discussion and demonstration of nursing care of the patient with terminal cancer; tour of the Swedish Hospital Tumor Institute with demonstration of nursing aspects of treatments given; demonstration of care of radiation reactions of patients being treated with radium, and care of patients receiving x-ray treatment, including pelvis x-ray. This lecture was well illustrated with lantern slides in color. The two one-hour sessions at which Rosalie Peterson presided were devoted to discussion and questions which included discussion of the joint responsibility of both hospital and public health nurse.

Representative state lay members of the Women's Field Army of the American Cancer Society joined students and teaching staff in a group luncheon at the Meany Hotel. The Washington Division of the Cancer Society paid the tuition, travel, and per diem of those nurses enrolled. Both public health agencies and hospitals released the nurses on pay for participation in the course.

A similar course in cancer control will be held each year at the University of Washington School of Nursing.

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Guides for Community Participation in Public Health Nursing

THIS IS the second in a series of guides for groups interested in studying community participation in public health nursing. Guide I, which appeared in the January issue of PUBLIC HEALTH NURSING, outlined the topic, "What the Layman Should Know About Public Health Nursing." Guide II, "How the Layman Contributes to Public Health Nursing," introduces another broad subject.

Those who are planning the conferences will need to remind themselves frequently that this guide like the others in the series is intended to offer suggestions to discussion leaders. Each session requires individual planning. Consideration should be given to the number of meetings devoted to each topic, the size of the group, and previous experience of members with public health nursing services. The brief text accompanying the questions is not inclusive and only highlights points of special interest. Reading the references listed after each question is necessary minimum preparation for the conferences.

It is suggested that the leader—

1. Encourage all members of the group to study the references. The material should be made as accessible as possible. Some reprints may be available from the NOPHN, and these can be supplemented by tearsheets from PUBLIC HEALTH NURSING and other publications, all being conveniently arranged in a folder or loose-leaf ring binder. Means for circulating references should be worked out.

2. Assign each question to one member for special study and designate her to serve as the resource person for that question.

3. Develop the lesson plan, building around the special interests and needs of the group.

4. Invite occasionally an outside speaker to talk for short periods on special topics or ask a member of the group to report about a special program or experience she has had. A stimulating device in securing active group participation is to draw on the experiences which individuals have had in the various volunteer activities in churches, clubs, and other forms of welfare work.

Again we reiterate the great value in having discussions jointly planned and jointly carried out by the layman and nurse. The layman will know best what are the group's special interests and needs. The nurse will relate these to public health nursing programs and situations.

Guide II

How the Layman Contributes to Public Health Nursing

1. Would public health nursing agencies need the layman's help if there were plenty of nurses?

The help of the layman will always be needed regardless of the available number of nurses. Mary Gardner, in discussing the function of a board of a voluntary agency says, " . . . there are few nurses who could not run their daily work without a board of directors. There are none, however, whose work would endure for even a short time without one. It would be like a cut flower, satisfactory enough while it lasts, but without roots or vitality, and without the power to grow and develop and reproduce." An advisory committee to a health department also gives continuity and stability to a service. It is important for an organized group of citizens to help interpret the service to the community; to help decide what services the agency will give; to obtain the necessary

QUESTIONS

1. Would public health nursing agencies need the layman's help if there were plenty of nurses?
2. What is the layman's responsibility for interpretation?
3. What responsibility does the layman have for the administration of public health nursing service?
4. Is it the function of a layman to help evaluate a public health nursing service?
5. Is a professionally trained campaign manager needed to raise money for public health nursing?
6. Are the budgets of tax-supported agencies determined by governmental ruling?
7. How does the layman help to influence legislation?
8. How can volunteers assist in public health nursing agencies?

money; and to decide under what conditions the nurses will work. Such decisions should be based on an understanding of the people for whom the service is intended, community needs, and standards in regard to organization, administration, and personnel practices. Therefore, the responsibility should be assumed jointly by members of the community and the professional staff.

The story of how a group of citizens kept a well baby clinic going in one community during World War II demonstrates one value of such a committee. This community was forced to curtail public health nursing activities because of the shortage of nurses. Members of the citizens committee of the health department, convinced of the importance of the clinic and sufficiently familiar with its activities, assumed responsibility for the set-up of the clinic. The nurse was present only when the clinic was actually in session. The committee also maintained community interest in other phases of the public health nursing program so that they might be resumed without break in service as soon as nurses were available.

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2. What is the layman's responsibility for interpretation?

Interpretation of public health nursing is a dual responsibility of the professional staff and interested lay workers. Interpretation of services involves presenting the public with information basic to their understanding of programs and problems. This is necessary if the service is to be properly used and the agency is to have adequate community support. There is another aspect to interpretation and here again the layman plays a major role. This is the broadening of the nurses' understanding of the community.

It is important that the story of public health nursing be related to what people are already interested in and that it be repeated many times in different ways. The layman is more likely to talk in terms which will be meaningful to fellow citizens. He or she can utilize many daily informal contacts as well as public meetings to tell people about the service. The nurse lives in the community sometimes only because her work has brought her there and consequently in the beginning at least she may be considered an outsider. The very fact that she is paid from community funds may be a handicap to her in participating in a publicity program. She is often not familiar with many aspects of community life

and needs help from the community in understanding it. If in the health department she works closely with the citizens committee; or if in a voluntary agency, with the board. She supplies the members with interesting information about the service which is being given. Gaining the interest and support of community groups, however, must be done jointly by staff and laymen. A nurse cannot do the job alone.

Interpretation must be a year-round program carefully planned to determine the objectives, media to be used, people to be reached, and budget that is expected. Mrs. Linderholm in "The Board as Interpreter" has told us what "interpretation" means. The kit for National Public Health Nursing Week prepared by NOPHN contains suggestions for a year-round program as well as for Public Health Nursing Week.

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Linderholm, Natalie W. Board as interpreter. PUBLIC HEALTH NURSING, January 1948, vol. 40, p. 27-31.

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Cook, Beatrice. Publicity pays—and how! PUBLIC HEALTH NURSING, May 1946, vol. 38, p. 243-245.

3. What responsibility does the layman have for the administration of public health nursing service?

A strong community service is dependent on the assistance of the layman for satisfactory administration. It is important that policies under which the work is carried on be determined on the basis of community characteristics as well as professional knowledge. The layman knows his community; the nurse and the health officer supply the technical knowledge.

Policies are more successfully carried out when those affected have a share in their development. Therefore a representative citizens' group should help to decide such things as what types of service the public health nurses will give; which sections of the community they will serve; what hours they will work; what they will be paid, and so forth. The community pays for the service and the community uses the service and therefore its citizens should help with its administration. Decisions should be made, however, with knowledge of what has been tried and proven successful in other communities and what is considered desirable practice by recognized authorities.

In a voluntary agency a citizens' committee carries responsibility for final determination of policies; in an official agency such committees serve in an advisory capacity to those who are legally responsible for the work. Both types of citizen participation are equally important. Every citizen should think of the health department as his agency and his responsibility. More will be said about the organization and functions of boards of directors of voluntary agencies and citizen advisory committees to health departments in Guide III.

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Mulder, Mrs. J. George. Board in a combination agency. PUBLIC HEALTH NURSING, December 1946, vol. 38, p. 656-658.

4. Is it the function of a layman to help evaluate a public health nursing service?

It is essential for everyone who is helping to direct public health nursing services to share responsibility for keeping the program in line with current standards and practices. In fact, if an agency keeps abreast of changing needs in a community a certain amount of evaluation or self appraisal should be going on all the time and a comprehensive study of the entire service ought to be made at least once a year. An evaluation should include consid-

eration of (1) the agency's service program as it relates to other public health nursing services in the community and unmet needs (2) its working relationship with other agencies (3) all factors contributing to the maintenance of a well-qualified staff and (4) the constitution and by-laws.

Too much emphasis cannot be placed on having such a study at regular intervals because changes which affect the public health nursing program are constantly going on. Developments in the field of science, current standards concerning community organization, changes in major health problems, and increasing demands by the public for all kinds of health services are factors which make it important for public health nursing agencies to adjust their programs from time to time. Today for example, the average life span is longer than it was 25 years ago, and therefore more people suffer from those conditions to which the older age group is susceptible. Many of this group who remain at home need the care of the public health nurse.

With greater demands upon them, it becomes increasingly important that public health nursing services be distributed as economically as possible. Therefore, it is important that insofar as possible services provided by two or more agencies in one community be coordinated. For example, in accord with the principle that public health nursing services should be administered by agencies whose only function is the administration of public health and public health nursing, the American Red Cross is recommending that services which were started by their local chapters on a demonstration basis be transferred to separate community agencies. Such important matters require careful and regular consideration in evaluating the quality of an agency's program and future outlook.

Much evaluation of public health nursing services can be done by a well-informed committee composed of nurse and non-nurse representatives of all the agencies concerned. A self-evaluation schedule included in the appendix of *Voluntary Health Agencies* listed among the references will be found helpful to such committees. Help from outside organizations also should be obtained from time to time. The NOPHN is prepared to make studies of individual agencies or community public health nursing programs.

References:

Schedule for a community survey of public health nursing. New York, NOPHN, 1944. This may be purchased in sections as follows: Community picture, 50 cents; Health departments, 30 cents; Industrial nursing, 30 cents; Voluntary agencies, 30 cents; School nursing service, 30 cents.

Gunn, Selskar M., and Platt, Philip S. *Voluntary health agencies,* New York, Ronald Press, 1945. Appendix 3, "Self evaluation schedule," p. 324.

Mansfield, Arline R. Lay group studies its community. PUBLIC HEALTH NURSING, June 1941, vol. 33, p. 370-372.

Winslow, C.-E. A. Has public health nursing reached its destination? PUBLIC HEALTH NURSING, December 1944, vol. 36, p. 609-616.

Sheahan, Marion W. Public health nurse's contribution in the annual planning of a public health program. *American Journal of Public Health,* December 1947, vol. 37, p. 1586-1588.

5. Is a professionally trained campaign manager needed to raise money for public health nursing?

One who has special preparation and knows the essential technics of this kind of promotion is undoubtedly a great asset to a voluntary public health nursing agency. However, few agencies can afford such help and, if they do have it, the professional fund-raiser still needs assistance. Participation in a year-round public relations program by a widely representative citizens' group is needed to obtain adequate support. A public health nursing agency which is an affiliated member of a community chest shares with the chest responsibility for interpretation and fund raising. A community chest plan is really a means of pooling effort and not one of transferring responsibility from the individual agency to this group. Income for voluntary agencies may be secured from individual contributions, fees from patients, or contracts with insurance companies. Visiting nurse services usually charge a fee for those who can afford to pay all or part of the cost. Since a public health

nursing agency is a nonprofit organization, fees are based on actual costs. It is essential that services be made available to all regardless of their ability to pay. Voluntary or tax funds are therefore needed to supplement earned income and cover the cost of services which are given entirely free and which are only partially paid for.

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Richmond, Clara. Health insurance plan of Greater New York. PUBLIC HEALTH NURSING, August 1947, vol. 39, p. 393-397.

6. Are the budgets of tax-supported agencies determined by governmental rulings?

Yes, and citizens groups can do a great deal to influence decisions of legislative bodies and to promote favorable public opinion toward governmental expenditures for health work. For example a budget is prepared by the health department and submitted to the appropriate legislative body for approval. Public opinion can do a great deal to influence its acceptance.

It is important for the layman to know how much tax money is spent on public health in his community. In 1945 the American Public Health Association estimated that at least one dollar a year for every person in the community was needed to provide enough public health facilities to make the community a safe place in which to live. However, while this estimate provided for public health nursing services of a sort it did not include bedside care. It is also required that each penny be used as efficiently as possible and that there be qualified people for every job.

In order to help obtain sufficient tax appropriations for health the citizen must himself have firm convictions about community needs. Participating in health activities will give him a more realistic appreciation of these needs and he will advocate expenditures with greater understanding.

To serve the public well both official and voluntary agencies need strong community understanding and support.

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Becker, Lucille. Building for health in my district. PUBLIC HEALTH NURSING, August 1945, vol. 37, p. 420-422.

7. How does the layman help to influence legislation?

It is both a privilege and a responsibility for every citizen in a democracy such as ours to help determine what laws will be made. With growing public interest in health, more and more bills related to this subject are coming up for consideration in legislative bodies. Therefore, lay groups will need to become better informed in order to make wise decisions about desirable legislation. The active participant in public health nursing affairs is more familiar with this subject and the strengths and weaknesses of existing health programs than one who has not taken part. He or she may therefore be a good person to help interpret the importance of pending legislation. Here again the opinion of the lay worker will carry more weight than that of the professional employee in the health department. Serving on legislative committees where bills are studied and where support is instituted for desirable legislation is another important function of the layman.

Every agency should have some definite plan for keeping its members informed about legislative measures which should be considered on the local, state, and national levels. However, each agency does not need to have a separate legislative committee. In fact,

joint committees representing all community health agencies, organized under a health council or a health committee of a council of social agencies may be preferable. Many state organizations for public health nursing and state nursing associations have been very helpful in promoting desirable legislation. Their efforts are stronger when their committees have informed lay representation. It is the function of such committees to know about pending legislation, to help interpret its implications to the public, to use their influence in having desirable laws passed and in opposing undesirable laws.

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Covey, Mrs. Wilkes P. An SOPHN backs legislation. PUBLIC HEALTH NURSING, November 1944, vol. 36, p. 587-588.

Public health nurses and legislative action. Editorial. PUBLIC HEALTH NURSING, April 1946, vol. 38, p. 149.

Social Legislation Bulletin. Social Legislation Information Service, 930 F Street, N.W., Washington 4, D. C. Summaries and discussion of federal bills. Special introductory fee, $2.50 for 3 months; $10 for a year. See also *Journal of the American Medical Association* (weekly) for summaries of health legislation in the states. League of women voters in your state is another resource.

8. How can volunteers assist in public health nursing agencies?

Everything the layman does without financial remuneration,—publicity, raising money, determining policies, and helping in clinics, is a voluntary activity. Too frequently only help which is given for the primary purpose of saving the time of nurses and clerks is thought of as "volunteer."

It would be impossible to estimate the amount of nursing time which has been saved by faithful citizens who participate in the service program. Helping to keep supplies in stock, summarizing statistical data, working in conferences and clinics, are among the valuable services frequently carried by volunteers. Thus, the nurse is able to spend more time with each patient, make more visits, and concentrate on the work for which she is specially prepared. The agency budget is stretched further and more service is given for each dollar spent. The patient, waiting for the doctor at the clinic, finds the volunteer hostess ready to talk with her and to help entertain the children. The volunteer, if the program is well planned, enjoys her work, gains a deeper appreciation for its value, and becomes a better interpreter. Often her interest and knowledge expand to the point where she is able to assume important responsibilities.

Agencies in which volunteer services are most helpful, have carefully planned programs for the selection, training, placing, and supervising of volunteers. Much of the success of volunteer programs is dependent on public health nurses who want the help of volunteers and who are able to make their contribution of maximum value. Successful volunteer programs are undertaken seriously and with careful planning by both layman and nurse.

Some communities have central volunteer bureaus which recruit and place volunteers for the various agencies in the community. However, each agency must first analyze the activities of its own service, to decide what volunteers can do and to plan its own training course and assignments.

As the demand upon public health nursing services grows it becomes more and more important for every agency to develop the kind of volunteer programs which will relieve the nurse of tasks which can be performed satisfactorily by volunteers.

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Help for the Arthritic

By BERNARD M. NORCROSS, M.D. and L. MAXWELL LOCKIE, M.D.

ARTHRITIS HAS become an increasingly important problem to everyone. It is the most prevalent chronic disease in the United States. There are 7,000,000 cases of arthritis in the United States today, causing a staggering total of 100,000,000 work days lost each year. There is not only a tremendous economic loss, but there is also a great amount of medical expense and physical suffering. Much can be done to reduce the total economic cost and suffering. Education of the public, to appreciate the significance of the disease as a social and economic problem and the necessity of providing adequate treatment for patients, would be beneficial. It is also necessary to help the patient to understand his disease, its treatment, and the need for cooperation in that treatment. The patient with arthritis needs considerable encouragement and reassurance. He frequently requires nursing and sociologic help. Much can be accomplished by the physician, but even more can be done with the aid and cooperation of the public health and the industrial nurse, who have frequent contacts with the patient.

To have a correct understanding of this problem, we must know the meaning of arthritis. Arthritis does not refer to a single disease, but rather to numerous diseases affecting the various joints of the body. The American Rheumatism Association has classified the great majority of cases of arthritis into the following types:

1. Infectious arthritis of proven cause, such as tuberculous or gonorrheal arthritis.
2. Probably infectious, but not proven, such as rheumatoid arthritis, rheumatic fever, Marie-Strumpell (spinal) arthritis.
3. Osteo-arthritis, or degenerative arthritis (hypertrophic).
4. Arthritis due to physical trauma.
5. Gouty arthritis.

The most important, from the standpoint of disability and economic loss, are rheumatoid arthritis, spinal arthritis, and osteo-arthritis, and we should concentrate our efforts on these diseases.

Rheumatoid arthritis is a systemic disease, which not only involves the joints, but often affects the entire body. Many physicians believe this disease is caused by an infectious agent probably related to the hemolytic streptococcus, but this has not been proven. Various factors, such as fatigue, emotional strain, acute infections, climate or trauma, may precipitate but do not cause rheumatoid arthritis. This disease, affecting more women than men, is most common in young people between the ages of 20 and 40. Rheumatoid arthritis often begins insidiously with the usual signs of a chronic infection—loss of appetite and weight, fatigue, weakness, fever, depression, nervousness, and anemia. Sooner or later, joint involvement occurs and frequently follows a symmetrical distribution. The joints commonly involved are the proximal interphalangeal joints of the fingers, the metacarpal phalangeal joints, wrists, feet, elbows, shoulders, knees, ankles, hips, and even the jaws in some patients. The proximal interphalangeal joints assume a characteristic spindle or fusiform shape and are warm, swollen, and painful on palpation or motion. The large joints (such as the knees) often show typical swelling because of the increased fluid in the joint and the marked atrophy of the muscles adjacent to the joint. Contractures and deformities of the joints may occur early in the disease as a result of muscle spasm and will lead to permanent stiffness (ankylosis) if proper treatment is not given. The skin shows a typical white, shiny atrophic

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appearance, and the palms and soles are cold and clammy. This type of arthritis causes most of the bed or wheel chair invalids.

TREATMENT IS an individual problem for each patient, but certain general procedures are followed routinely. The general care of the patient is the most important and yet usually the most neglected part of treatment. Unfortunately, many physicians treat only the joint manifestations and overlook the systemic phase of the disease. Adequate rest, both mental and physical in nature, is essential. Many patients have been advised to exercise their joints to prevent stiffness and they must be taught to disregard this aggravating practice. Rest in bed is essential when there is acute inflammation and swelling of the weight-bearing joints and when there is rapid or severe progression of the disease. In many individuals, when the disease is not severe, 10 hours rest at night and 1 hour during the day is sufficient.

The patient often becomes depressed because of the chronicity of the disease and needs constant encouragement and reassurance regarding his future. He should never be promised a "cure," but should be given a hope of 90 percent improvement if he cooperates. The physician and nurse can accomplish much with a sympathetic and optimistic attitude.

Good nursing care of course is a necessity for the bed patient. The mattress must be firm and a board should be placed between the mattress and the spring, to support the spine. A pillow or a blanket roll placed against the soles of the feet will support the bed clothes, preventing foot drop. Splints or casts should be applied to very painful joints or when there is any evidence of contractures. These splints must be removed several times daily and the joint put through its full range of motion. Aspirin or sodium salicylate is usually sufficient to control pain.

When correctly employed, physiotherapy is one of the most important methods of treatment. The use of heat in any form is beneficial, whether it consists of hot, wet packs, an infra-red lamp, bakers, or an electric pad. Hot-wet packs, or the infra-red lamp (used at a distance of about 30 inches, where it will feel only warm) are preferable. Diathermy should not be applied to any acutely inflamed joint. The use of light massage is also beneficial when applied to the adjacent muscles and not to the joint. Even the bed patient should be given carefully graded exercises which should never be used to the point of causing pain.

THE DIET of an arthritic patient should be adequate in calories, vitamins and proteins. There are no foods which are contra-indicated in this type of arthritis. If the patient is underweight, a high caloric diet should be used; a low caloric diet is necessary if the patient is obese.

Iron and transfusions are valuable to correct the anemia which is very common in patients with this disease. Often the improvement seems greater than can be accounted for solely by the increase in hemoglobin or red blood cells.

Injections of gold salts form the best single method of treatment for this disease today. Used in correct dosage, improvement can be expected in 75-80 percent of patients. The incidence of toxic reactions has been markedly reduced by using smaller doses and by more careful observation of the patient. The use of a new drug, British Anti-Lewisite has helped to minimize reactions caused by gold therapy.

X-ray treatment of the involved joints is valuable in relieving the pain and often makes the patient comfortable when other measures have failed. This relief usually lasts for a considerable period of time.

A definite focus of infection involving the teeth or tonsils should be treated especially in the early state of rheumatoid arthritis. Although these procedures will not necessarily cure the arthritis, they improve the general health of the patient and often prevent aggravation of the disease.

A series of 4 to 6 injections of small doses of typhoid vaccine intravenously at 2-or 3-day intervals, to produce mild febrile reactions, is often of great benefit to the patient. This type of therapy should be restricted to hospitalized patients.

Other drugs, such as streptococcus vaccine or foreign protein, are helpful when other methods of treatment (gold or typhoid vaccine) cannot be employed because of the advanced age or poor physical condition of certain patients. High potency Vitamin D

preparations (150,000-300,000 units daily) are of benefit in a few individuals. There are some toxic reactions to this type of therapy and its routine use is not advisable.

A change of climate has a marked benefit in selected cases. If the patient is financially able, it is advisable for him to spend the winter in a warmer and milder climate.

MARIE-STRUMPELL ARTHRITIS is a chronic progressive disease occurring usually in young men between the ages of 20 and 40, involving the spine, and, in many cases, the hip or shoulder joints. The cause is not known but many physicians feel that it is a variety of rheumatoid arthritis. The disease often begins insidiously with vague pain or stiffness, loss of weight and strength and low-grade fever. Progression of the disease is sometimes slow. The outstanding features are pain, muscle spasm, and limited motion of the spine, usually beginning in the lower back (sacroiliac joints). Later there may be progressive involvement of the rest of the spine and neck, lack of chest expansion, and in many cases, involvement of the hips or shoulders. The spine becomes progressively more rigid, producing the so-called "poker spine." There may be kyphosis (forward curvature) of the spine and marked loss of muscle power. Often these patients are unable to stand erect or to turn the head without moving the entire body. This disease can interfere seriously with a person's normal life. The diagnosis can almost always be made early in the disease by the x-ray finding of changes in the sacroiliac joints.

Intensive treatment will do much to prevent deformity and to relieve discomfort. Rest in bed is a very important part of treatment in any case with much pain, muscle spasm, or deformity of the spine. The mattress must be firm and a bed board is essential. X-ray therapy is the treatment of choice to relieve the symptoms of this disease and should be administered by a competent radiologist. The use of infra-red heat and light massage is valuable in relaxing muscle spasm and relieving pain. The patient must be instructed in the mechanics of maintaining proper posture and he should perform deep-breathing exercises several times daily. In most cases, a Taylor brace is beneficial in the prevention of deformity of the spine. Each patient must understand his disease and the necessity of leading a regular life and obtaining the correct amount of rest. He must be careful to avoid strenuous physical work and fatigue.

OSTEO-ARTHRITIS (hypertrophic arthritis) is a disease of late adult life and usually occurs in the weight-bearing joints of obese individuals. It is the result of constant "wear and tear" on the articular structures and is a degenerative process involving first, the cartilage, and later the bone and lining membrane of the joints. There is no evidence that infection is the cause of this disease. In women, it is often precipitated by the menopause. Osteo-arthritis sometimes exists for years without causing any symptoms, until some minor trauma to the joint acts as a precipitating factor.

The early symptoms consist of mild stiffness in the morning, numbness of hands and arms, or slight enlargement of the terminal finger joints. The enlargements of the terminal finger joints, diagnostic of this type of arthritis, are called Heberden's nodes. The other commonly involved joints are the knees, neck, spine and hips. There are often very audible creaking or grating sounds in the involved joints. The course of the disease varies from slight stiffness and aching to marked pain and restricted motion. Rarely is there swelling due to fluid in the joint, and it rarely produces ankylosis or deformity such as occurs in rheumatoid arthritis.

Again, rest is one of the most important factors in treatment. The patient must avoid excessive use or undue strain on the involved joint. When the weight-bearing joints, such as the knees or hips, are involved, walking and standing for long periods of time should be avoided. As many of these people are overweight, a reduction diet is a necessity for improvement. Occasionally, such drugs as thyroid, when the person has a low basal metabolism, or Benzedrene, help to reduce weight. The use of physiotherapy, consisting of heat, massage, and carefully supervised exercise, is beneficial. Various orthopedic measures, such as a good foundation garment, arch supports or metatarsal bars, a cane, or even crutches, are necessary for correct posture and weight bearing. The mattress should be firm and a bed board should be used to prevent sagging. Painful joints are often relieved by the injection of procaine. The use of estrogenic

substances produces marked relief in the menopausal patient. Occasionally x-ray treatments or injections of foreign protein will help.

This brief discussion is intended to present the medical concepts of arthritis in order that there will be a better understanding of the problems involved in the therapy and rehabilitation of arthritic patients. The utmost cooperation between the nursing and medical professions is necessary for successful treatment of these patients and to effect a reduction in the tremendous economic loss to the community.

MEETING CALCIUM NEEDS IN MATERNITY

"WHAT CAN I do for my expectant mothers who are without a milk supply?" "Three of the twelve mothers at my nursing conference today refuse to drink milk." And in one county prominent in dairy production in the state 24 of 25 pregnant women at the health department office one January morning were without milk at home!

A Chinese physician had discussed with us how she supplied her mothers with bone ash when other sources of calcium became scarce. A Bolivian physician mentioned the addition of ground bone meal to the daily menu as an ancient dietary custom in her country. Solving the problem of many of our maternity patients' calcium needs in Mississippi was dependent on working out, in these days of inflation, a good "five-cent program."

Mississippi's 65 county health departments now have available a preparation called C-D Compound, which will provide each mother who has a calcium deficiency in her diet with 1.5 grams of calcium and 1,000 units of vitamin D each day at a cost of 3 cents a month. The compound, an attractive white powder neutral in taste, is mixed and packaged in one-third pound lots by each department to save the 11-cent packing charge, which would otherwise triple costs.

The basis of the compound, dicalcium phosphate, is ordered in 100-pound lots directly from Monsanto Chemical Company, 924 Marx Building, Birmingham, Alabama, at a cost of approximately $8 per 100 pounds. The source of vitamin D, Fleischmann's Hydee Yeast, is ordered in 1-pound lots from Standard Brands, New York City, for approximately 65 cents. The powder is mixed and packaged in one-third pound packages in paper sacks (one-half pound size) which cost about $1.18 per thousand.

One hundred pounds of dicalcium phosphate and one pound of Hydee Yeast will be sufficient to prepare three hundred one-third pound packages of C-D Compound, each representing one month's supply for one patient, the total amount is sufficient for 50 patients for 6 months. Instructions to the patient are that she should take 2 level teaspoonfuls in a half glass of cold water once daily.

The usual drug house preparations containing calcium and vitamin D cost approximately $1.75 for a month's supply and usually provide the mother with only 0.75 grams of calcium daily. It is not common knowledge in public health circles that preparations of vitamin D are available commercially at prices as low as 6 cents for 1 million units, a year's supply for 3 persons.

Health departments in Mississippi use the C-D Compound for either expectant or lactating mothers receiving less than 3 glasses of milk a day or without 1,000 units of vitamin D a day or both. Other uses for the compound easily suggest themselves, such as use in the preschool program, among children in tuberculous families, et cetera, who are without milk or vitamin D or both. It is not being used in the infant health program. (An instruction sheet will be sent on request to the Division of Maternal and Child Health, Mississippi State Board of Health, Jackson, Mississippi.)

Demonstrations of the compound at maternal and child health conferences always include demonstrations of milk, and no suggestion is made that it is a substitute for milk.

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Non-Nurse Professional Workers

By DOROTHY E. WIESNER

AMONG THE 641 public health nursing agencies replying to the 1947 NOPHN Yearly Review, 83 reported the full-time employment of non-nurse professional workers. More than 25 percent of the state and municipal health departments reported the employment of such persons; between 10 and 20 percent of the county health departments and combination agencies; 8 percent of the nonofficial agencies. More than half of the agencies employing 100 and more nurses employ such workers.

Among the 83 agencies in the sample, 209 non-nurse professional workers were reported. —58 in state health departments, 41 in county health departments, 47 in municipal health departments, 53 in nonofficial agencies, 10 in other types of agencies. (Table 1.)

Nutritionists constituted more than one third of the 209 positions. Next in numerical order were social workers. Only three other types of positions accounted for more than 10 workers,—statisticians, physical therapists, and dental hygienists.

Table 2 shows medians and ranges of salaries for six of the groups of non-nurse professional workers. Some of the persons in health departments undoubtedly function both within and without the nursing divisions. The wide ranges of salaries, however, arouse curiosity as to variations in the qualifications of the persons for whom data were given, but this information was not requested.

Nutritionists' salaries fall into the more usual pattern around the median, but those of statisticians vary most oddly, the lowest salary, $1620, being paid in a county health department, and the highest $5040, in a state

TABLE 1. NON-NURSE PROFESSIONAL WORKERS EMPLOYED IN FULL-TIME POSITIONS IN 641 PUBLIC HEALTH NURSING AGENCIES, 1947

Type of non-nurse professional worker	Total all agencies	Type of Agency					
		State health departments	County health departments	Municipal health departments	Boards of education	Non-official agencies	Combination agencies
Total all types of non-nurse professional workers	209	58	41	47	3a	53	7
Nutritionist	69	33	5	7	....	22	2
Social worker	29	6	15	6	....	2	....
Statistician	26	5	6	6	....	8	1
Physical therapist	20	6	3	1	....	9	1
Dental hygienist	12	2	....	5	3a	2	....
Health educator	10	3	3	3	....	1	....
X-ray technician	5	....	....	4	....	1	....
Occupational therapist	4	....	....	....	....	4	....
Mental hygienist	3	....	....	1	....	1	1
All others	31	3b	9c	14d	....	3e	2f

a. Boards of education were not asked to report on non-nurse professional workers.
b. Dietitian (1); librarian (1); parent education consultant (1)
c. Artist (1); dentists (2); non-nurse executive (1); psychiatric attendant (2); sanitarian (2); syphilis investigator (1)
d. Dental assistants (9); welfare investigator (1); social investigator (1); position not stated (3)
e. Comptroller (1); director of volunteers (1); rehabilitation worker (1)
f. Non-nurse executive (1); play school instructor (1)
g. Includes psychiatric and medical social workers

health department. Because salary data of this kind are difficult to find, even this small sample is of interest. Social workers' salaries show a median of $3060; statisticians, $3043; health educators, $3038; nutritionists, $2890; physical therapists, $2486; and dental hygienists, $2340.

Positions of non-nurse professional workers on payrolls of public health nursing services have probably been increasing as preparation in various fields becomes more consuming of time, energy, and money. The figures here presented are as accurate a picture as could be obtained by available resources at this time.

TABLE 2. SALARIES, INCLUDING BONUSES, PAID TO FULL-TIME NON-NURSE PROFESSIONAL WORKERS, APRIL 1, 1947

Kind of worker	Total workers	Salaries: $3900 and over	$3600 to 3899	$3300 to 3599	$3000 to 3299	$2700 to 2999	$2400 to 2699	$2100 to 2399	$1800 to 2099	Less than $1800	Median salary
Nutritionists	68[b]	3	5	8	12	15	14	9	2	....	$2890
Social workers[a]	29	3	2	5	5	6	3	1	4	....	3060
Statisticians	25[a]	4	1	1	7	2	4	1	4	1	3043
Physical therapists	19[b]	....	1	....	1	2	7	5	2	1	2486
Dental hygienists	12	....	....	....	1	....	4	1	5	1	2340
Health educators	10	....	....	1	4	2	3	....	....	....	3038

a. Includes medical and psychiatric social workers

b. Excludes one worker for whom adequate salary data not provided

HOW MANY NURSES IN 1960?

IN ORDER to maintain current standards of professional nursing, from 500,000 to 550,000 nurses will be required in the United States by 1960. Needs as they will appear in 1960 cannot even be approached. These recent estimates by the Women's Bureau of the U. S. Department of Labor made in cooperation with the National League of Nursing Education represent a realistic appraisal of possible attainment rather than an estimate of what ideally is desirable. About twice as many nurses would be required to provide mental patients and others with the amount of service they need.

The League estimates that there will be about 37,700 graduates from schools of nursing in 1948; 20,600 in 1949; and 26,700 in 1950. In order to reach the half million mark, graduations would have to average from 43,000 to 45,000 annually between 1951 and 1960.

Were the 1960 goal reached, the Women's Bureau estimates that 76,700 nurses—the equivalent of 1 to 2,000 persons—would be employed in public health. Other fields of nursing would include: non-federal hospitals, 315,700 nurses; private duty, 100,000; federal services (government hospitals and agencies) 36,800; and industrial establishments, 25,000.

In arriving at its estimates of nurses needed by 1960, the Bureau based its consideration on the following current standards in nursing:

1. Existing programs for preparing professional nurses. (In 1946, 6 percent of entering students planned to take the degree program; 94 percent, the diploma program.)

2. Existing requirements for entering the profession. (Ninety-seven percent of schools require a high school diploma; 3 percent one or more years of college work.)

3. Continued gradual increase in the use of trained practical nursing personnel but no immediate marked change in this respect.

4. A 48-hour week in institutional nursing with 2 weeks' vacation with pay, and a gradual attainment of the 40-hour week in other types of nursing service.

5. Continued increase in the average daily census of patients in hospitals at the rate of civilian hospitals in the period 1941-1945.

6. A high national level of economic activity with relatively full employment.

7. A peacetime Army and Navy.

8. A 1960 population of 153,375,000, as estimated for that year by the Bureau of the Census.

Also taken into account in Bureau estimates was the fact that every year approximately 6.33 percent of the total number of active graduate nurses will leave the profession. This figure represents the actual attrition rate among professional nurses during 1930 to 1939.

Experiment in Apprentice Training

By SOPHIA A. JARC, R.N.

ON APRIL 1, 1947 the apprentice public health nurse program of the New York State Department of Health was formally launched. The budget was approved!

The impetus to begin experimentation in field training grew out of the dearth of qualified personnel to fill the many staff nurse vacancies and the pressing demands of an expanding health program.

The need to recruit the young graduate nurse before she embarked upon another field of nursing was apparent. To be eligible for a state scholarship for a course in public health nursing, a year's experience in nursing is required. Many good applicants were lost to other specialties during this first year. We thought it reasonable to expect that at least 10 percent of each graduating class could be recruited for public health. The crying need obviously was to plan a program which would absorb this young graduate nurse group, thereby building a reservoir of potential trainees from which candidates for postgraduate preparation in public health nursing might later be selected.

Another vital issue which led to this experimentation was the limited and curtailed enrollment in university public health nursing programs, resulting from overcrowded field training centers around the universities. The future supply of qualified public health nurses was being cut at its source! The voluntary agencies outside of university centers, which formerly helped by giving four months' field introduction to the state trainees, were also feeling the pressures of the times and could no longer meet our request for this service. An experience of four months in a field agency was one part of the plan which was followed in the first few years that training funds were available under the Social Security Act. The new apprentice program is essentially an extension or adaptation of the earlier plan.

Faced with the existing bottlenecks in the traditional training methods, and the increasing demand for nursing service in the rural area, the official agency, because of its expanding health program, felt it imperative to try other methods, experimental though they might be, to meet personnel needs.

During the past few years the rural public health nurse has been called upon to give more bedside nursing care, in addition to her maternity, child health, tuberculosis, immunization, syphilis, and orthopedic programs. There has been a growing realization that a complete community nursing program includes a certain proportion of work which a registered professional nurse could do but which is not typically public health nursing work. It is within this area, the bedside care programs as an integrated part of family health service in a rural area, where it was thought experimentation could be tried in introducing the young nurse, the apprentice public health nurse or "fledgling," under the daily guidance of a senior public health nurse. In Utica, Buffalo, and Rochester, the health departments and visiting nurse services are working out a coordinated program, the voluntary agency offering the bedside service.

COOPERATIVE PLANNING FOR THE PROGRAM

In our planning Mary C. Connor's definition of apprenticeship has been kept in mind:

> The purpose is to select the nurses best suited for public health nursing, to prepare them through a planned introduction and a continuing staff education program to participate, under supervision, in the program as trainees. Essentially, an apprenticeship is training in the specific duties of a position. According to recommendation of the Committee on Professional Education of the American Public Health Association, it refers to the first year, or so, of employment and precedes postgraduate study.

To insure the soundest thinking and planning in this new training venture much "shopping around" has been done to gain the wisest

Miss Jarc is education consultant in public health nursing, Division of Public Health Nursing, New York State Department of Health.

professional counsel. Conferences were held on a statewide basis with the advisory nursing council of the Division of Public Health Nursing composed of directors of university public health nursing programs, directors of voluntary and official public health nursing agencies, both urban and rural, and with state, city, and county health officers and supervising nurses who meet in conference on administrative problems.

Major problems were crystallized through discussions with individuals and groups holding different points of view. Such questions as the following were considered:

1. Was field experience in advance of university preparation a sound procedure?
2. Would there be difficulties in selecting the right recruits when civil service jurisdiction was involved? Would local interests in selected nurses be a pressure point for the administrator since the objective criteria for selection were those which might be met by most young graduates eligible for professional registration in New York State?
3. Were there enough areas relatively ready to be used as field training centers? Was the bedside care program sufficiently well developed to offer the young nurse a reasonable percentage of bedside nursing through which she would be introduced to other aspects of family health service?
4. Could the apprentice public health nurse be protected from assignment to more responsibility than she was prepared to accept in view of service pressure and staff shortages?
5. Was there a danger of developing an inflated community service with no long-range plan for continuity unless budget for permanent staff could be assured?
6. Should an apprentice program which is related to professional preparation be entirely state and/or Federal supported?

The answers to all of these questions are still being studied.

There was an almost unanimous response to the idea of apprentice training preceding university education, much of the need stressing its possible aid in recruitment. The developed procedures in a sense were aimed to control the hazards implied by the questions enumerated above.

A subcommittee of the state advisory nursing council was appointed to study the problems and outline the safeguards of a new training program for nurses who had no postgraduate preparation in public health nursing. This subcommittee, composed of representatives from the universities, voluntary and official agencies, worked together formulating the policies which involved (1) selection of the training centers (2) recruitment of apprentice public health nurses (3) selection of candidates (4) introduction and content of the training program, and (5) evaluation of apprentice public health nurse (or APHN).

All the policies were compiled in a manual which was sent to all agencies and universities participating and to selected groups of universities and voluntary and official agencies for their information and reaction. A total of 87 manuals was distributed.

SELECTION OF THE FIELD

To safeguard the integrity of the APHN training program, criteria for the evaluation of centers for field practice were drawn up. Fifteen training areas were selected for evaluation jointly by the field supervising nurses, the assistant director and education consultant from the central office staff. In the main, these criteria serve as an excellent tool to improve the general public health nursing service. The criteria in order of their importance are:

1. Good administrative directions, i.e., public health committee, county health department, et cetera
2. Well qualified staff with teaching point of view, and adequate in number to give student guidance:
   a. Full-time health officer interested in education of nurses
   b. Well-qualified supervisor whose total administrative responsibility allows time for adequate supervision of staff and students
   c. Interested staff public health nurses with ability and qualifications to function as senior advisors
3. In-service staff education program,—conferences, classes, et cetera.
4. A progressive program including all phases of family health service which might be in the agency, or arranged for by the agency. The program will include such public health activities as:
   a. Giving bedside nursing care. Indispensable to the apprentice program
   b. Participating in the maternity, infancy and child hygiene program, including bedside nursing care to mothers and newborn infants; participating in child health conferences and immunization programs. Indispensable to the apprentice program
   c. Promotion of good relationship of laboratory services to health program
   d. Promotion of and participation in health education activities
   e. Medical rehabilitation
   f. Promotion of effective lay participation
   g. Participation in developing a hospital referral system and other cooperative programs with local health and welfare agencies
   h. Participation in tuberculosis and cancer control programs
   i. Promotion of good community hygiene and sanitation

5. Ratio of students to staff 1 student to 3 staff nurses or 1 apprentice to 1 senior advisor, including students
6. Readily accessible area with sufficiently concentrated population to make it possible to cope with transportation problems
7. Restricted case load of few selected families so that APHN may learn well the fundamentals of home nursing service
8. Coordination of activities of health agencies, as evidenced by the formation of a community council

SELECTION OF CANDIDATES

In selecting the candidates for the apprentice program, nurses were chosen who not only had performed well during their basic school of nursing program but who, if selected for advanced education, would be eligible to matriculate for one of the approved university public health nursing programs. The requirements were:

1. High school graduation and eligibility for matriculation at an approved university
2. Graduation from an accredited school of nursing connected with a general hospital having a daily average number of 100 patients or a minimum of 50 patients with one or more affiliations affording supplementary preparation
3. License to practice as a registered professional nurse in New York State
4. Satisfactory recommendation from the school of nursing and other work references (Transcript of school of nursing record is obtained)
5. Satisfactory report of complete physical examination with chest x-ray and tuberculin test
6. Satisfactory personal interview with representative of the health department in the local area
7. Nurse's indication of interest in preparing for the public health field insofar as she is able to judge
8. Freedom to accept assignment to any area of the state
9. Current New York State driver's license or willingness to secure this as soon as possible

CONTENT AND LENGTH OF PROGRAM

A basic guide in instruction, scope of assignment plan for observation, and supervision of apprentice public health nurses was prepared and discussed with the responsible supervising personnel in the 15 training centers throughout the state.

The emphasis of the introduction is on the bedside care program. As the nurse develops skill in home sickness care service, she is introduced to maternity, infancy, and child health services as part of organized community service, later to other phases of family health service as well as observation and some practice in clinic service.

The general aims of the apprentice program are to help the graduate professional nurse gain or recognize:

1. The necessary adaptation to the home of hospital bedside nursing technics and the importance of sound technics as a foundation for safer public health nursing
2. Skill in making a good contact in the home
3. Appreciation of the patient as an individual, not as a case; as a member of a family and of the community
4. The need for health teaching on a family basis
5. The value of good records
6. The value of knowing community resources and using them, at least in relation to the patients she carries
7. The value of lay participation in public health nursing
8. The importance of a community plan for health work

In developing a program for the apprentice to include approximately 50 percent bedside care caseload, it has been necessary to proceed cautiously, to insure that once a heavy bedside program is initiated, and the community accustomed to the service, it can be continued through the assignment of new recruits.

At the present time the four months' period of introduction has been planned for APHN experience in order to expedite the preparation of the number of nurses needed for the field program and to assure use of all the training funds which have been allocated for their university education.

As the program proves itself, the permanent apprentice experience is expected to cover one year, during which period could be included two months' clinical nursing experience in one of the specialties, depending upon the content of the individual nurse's school of nursing program,—tuberculosis, cancer, orthopedics, or psychiatry. Rich clinical experiences with strong educational programs have been underway for some time in the state's special hospitals for these diseases. Sending the apprentice to a school to observe a total school health program is also a possibility in this year's try-out experience. The first group of apprentices appointed, averaged 5-months' field experience before they left for the university in September 1947.

SALARY

The majority of the apprentices are on the state payroll, receiving an annual salary of $2040 or $170 per month. This salary was decided upon to meet the minimum received by the registered professional general duty

nurses in a state hospital whose qualifications are comparable.

EVALUATION OF THE INDIVIDUAL

At the end of three months in the field, the work of each apprentice and her suitability for further training were seriously appraised with emphasis on her adjustment in the bedside care program. The following were considered:

1. The apprentice nurse's general fitness for public health nursing as a career, her attitude and interest in the APHN field program, her vitality, appearance and endurance, adaptability and adjustment to APHN program, judgment and dependability, and her nursing skills. The latter included approach in home, ability to carry out procedures, organization of work, teaching, records, and use of community resources.

2. Does supervising nurse recommend that APHN be accepted for further preparation, that is, stipend for public health nursing university program? Is applicant a good risk as evidenced by first three months of APHN program?

3. Does APHN realize the obligation for two years' field service as a public health nurse in Upstate New York in return for stipend (if she is chosen by the Committee on Selection for this privilege)?

Out of a group of 51 APHN's, on both state and local payrolls, 15 dropped out for the following reasons: 7 for marriage; 4 not suited for public health nursing work; 1 preferred hospital nursing; 1 for illness; and 2 for illness within their family groups. Four chose to remain in the field for the 1 year's experience before entering the university.

Considering the momentum with which the program was started and the personal responsibilities of several of the applicants, we are not disturbed by the loss in this first group. As far as the results are concerned, it is far more desirable to have them make a decision at this point and drop out rather than enter a university program for a year and find that other interests supersede the career for which they were preparing.

The field reports forwarded to the university on each apprentice include the following: supervisor's report; apprentice's own evaluation of what the experience has meant to her; and a statistical summary of the total experience, including classes, demonstrations, field trips, home visits, clinical service, and reading done.

The field supervisors have worked hard with the first group of apprentice public health nurses, observing the purpose and integrity of the training program. There has also been a healthy competitive spirit among the senior nurses, each seeking the best experience for the apprentice assigned to her. The program has also brought out much latent supervisory talent among the senior nurse group from which candidates for future preparation in supervision are to be selected.

Representatives from four universities within the state have visited some of the training centers and have seen the apprentices in action, as they presented and discussed their family service studies. The interchange between the university instructors and the field staff has been a healthy experience for the young nurse.

OUTCOME OF THE PROGRAM

In September 1947, 32 apprentices began two semesters of postgraduate study in an approved university public health nursing program. Twenty-nine of these nurses have been awarded state scholarships, consisting of tuition up to $510 and a monthly stipend of $125 for two semesters. Three apprentices, former army nurses, have gone to school on the G.I. Bill of Rights. The 32 apprentices selected 10 different universities; one third chose universities outside New York State.

After the university preparation, each trainee is obligated to return to New York State to fulfill the two-year field service requirement in return for the state stipend invested in her. It is hoped that the three G.I. nurses who have had a taste of field work as APHN's will choose to return after their university preparation.

Although it is too early to come to any final conclusions about the program, since only one group of 51 apprentice public health nurses has been in the field, the following tentative conclusions have been reached:

1. A reservoir of good candidates for career training in public health nursing has been built up. The weak nurse can definitely be eliminated during the try-out program.

2. The look into the public health nursing field has stimulated interest and desire for

further career training. A feeling for or an insight into health problems has been developed. This should help make the theory at the university more meaningful.

3. The individual apprentice public health nurse's evaluation of the training program indicates that she realizes her need for university preparation to qualify for the responsibility of public health nurse for field service.

4. Through local recruitment for apprentice public health nurses and later field assignment in local areas, the supervising nurses have learned through experience how important the collection of all credentials is in selecting the best recruit for the try-out program thereby saving the agency's time and effort in the long run.

5. It has been possible to so plan that the apprentice has definitely been helpful in assisting with the agency's program at her level of preparation with value to the agency and to her educational growth.

6. Relationships with schools of nursing and hospital groups have been strengthened as they have seen their own new graduates go into the field and develop under the apprentice program.

7. The program has demonstrated that the official agency can offer the young nurse an introduction to public health nursing, preserving what is good in the old pattern and adding the fresh approach of a broad community health program.

SUMMARY

Those of us in touch with the program have reached a few opinions which might be considered direction for the future. This apprenticeship plan is sound as a prerequisite to university education for public health nursing. A well-directed general community program offers opportunity to provide the apprentice with experience of progressive responsibility of value to her and of value in service to the agency. One year in length would seem the upper limit of time so spent and four months the minimum. The agency is offered a continual medium for stimulation of the type to maintain progress in program and staff development.

Apart from these values are problems which pertain to the work of universities who must adjust their programs to the students who enroll. These related problems and a review of progress will be discussed with our state advisory nursing council which will be invited to meet in the next two months.

Feeling so keenly a gap between present field service and even the relative ideal which we would wish to offer to a student we gathered courage from a brief message which reached us via the editorial page of a newspaper. It was entitled "Don't Wait" and ends with the thought, "Indeed the 'ideal time' so praised and waited for by resolute perfectionists never comes. The best things have generally been done in the worst of times."

This apprentice program is not the best but it is good, nor is it new in a sense. It is, however, a sincere approach to a very real personnel problem upon which depend so many services without which the public health program cannot progress.

Presented to the Collegiate Council on Public Health Nursing Education, New York City, October 4, 1947.

Reviews and Book Notes

STATE CENTRAL CASE RECORDS AND LOCAL CASE REGISTERS MANUAL

By Herman E. Hilleboe and Francis J. Weber. Washington, D.C., Federal Security Agency, USPHS, Tuberculosis Control Division, 1947. 88 p. Free to agencies conducting tuberculosis control activities.

This manual has been prepared in response to urgent requests from state health departments, which either have or are developing tuberculosis control programs, for assistance in the development of uniform and widely used state central case recording systems throughout the country.

It is based on research and extensive field studies, particularly in the states of Oregon and Kansas, and represents the combined efforts of experienced workers in the fields of public health, tuberculosis, and statistics.

The steps to be taken to organize, install, and maintain a state central record system, and information on how it differs from a local case register are simply and clearly presented. Liberal use is made of diagrams and illustrations with samples of various forms and record system cards needed for the operation of both systems.

The definition as given in the text, "a State Central Record System for tuberculosis and the local tuberculosis case register may each be defined as a system of records for maintaining a current summary of pertinent medical and public health data on those proven and suspected cases of tuberculosis which, according to health department policy, require some type of supervision," shows that this manual should not only be used by the record analyst and clerk. It should be used also by all health workers participating in the tuberculosis control program whether they are working in clinics, hospitals and sanatoria, laboratories, army, navy, and veterans' hospitals, welfare agencies, vital statistics bureaus, state and local health departments, public health nursing divisions, or as private physicians.

The authors point out the important role the public health nurse plays in the functioning of state and local registers in reporting the change of address, change in medical supervision and examination of patients, and other pertinent medical data that comes to her attention because of her frequent contact with tuberculosis patients.

On the other hand, the local register serves her as a direct guide in the management and supervision of her case load. Every public health nurse will find it extremely worth while to study the philosophy and basic principles of this manual in order to evaluate and unify her own activities in relation to the total tuberculosis control program.

The format of the book is modernistic and functional in design. It is loose-leaf, with substantial plastic rings which permit the book to lie flat and open on the desk. There is a liberal use of red lettering and titles with wide margins. Other useful features include a chart for comparison of the state and local systems, an index, and a glossary.

—WINIFRED I. PATTERSON, *Educational Director, Veterans' Administration, Oteen, N. C.*

LEGAL ASPECTS OF NURSING

By Milton J. Lesnik and Bernice E. Anderson. Philadelphia, J. B. Lippincott, 1947. 352 p. $4.00.

Two well qualified authors have prepared this text in an "effort to condense, simplify and clarify the law for students of nursing." A glossary of legal terms helps interpret the technical language necessarily involved.

Considerable emphasis is given to the development of nursing as an occupation coming under legal control and to the enactment of nurse practice acts. It is these acts, defining, prescribing, and limiting the practice of nursing, which give the law its basis for interpretation of the functions and responsibilities of professional nurses. Valuable information regarding these acts is included in the appendix.

The legal aspects of contracts and consequences of the same, and the legal status of nurses are clearly presented. The discussion of the civil wrongs redressable in civil pro-

ceedings, called torts, includes negligence, assault and battery, and false imprisonment, as restraint may be termed. This discloses the serious involvements attendant upon the commonest nursing procedures and relationships, which apply in either a nurse's professional employment or Good Samaritan role. The section on slander and libel should make every nurse guard her oral and written expressions of opinion. Criminal action such as false representation as an R.N. is considered as a wrong against the public. Instructions regarding wills are clearly outlined but no mention is made of holographic wills.

The latter part of the book dealing with the legal aspects of formation of the government shows how and through what channels the law operates.

If this material was used, as suggested, for a course for student nurses, it would have to be presented with great insight and discrimination or its implications would completely overwhelm the young student. The book would be a valuable addition to every nursing library as the examples are drawn from all fields of nursing.

—MILDRED E. NEWTON, *Assistant Dean, School of Nursing, University of California, San Francisco, California.*

COMMON CONTAGIOUS DISEASES

By Philip M. Stimson. Fourth Edition. Philadelphia, Lea & Febiger, 1947. 503 p. $4.00.

This is not a book devoted to communicable diseases, but is definitely limited to thorough presentations of one segment of this vast field, namely contagious diseases, thus adhering to the established title.

Chapter I deals with the principles of contagion, and emphasizes the relationships of the epidemiologic triad, host-agent, and environment.

Chapter II is devoted to the etiology, clinical manifestations, prophylaxis, and treatment of serum reactions.

Successive chapters are devoted to detailed discussions of Diphtheria, Vincent's Angina, Scarlet Fever, Measles, Rubella, Whooping Cough, Mumps, Chicken Pox, Smallpox, Meningococcus Meningitis, and Poliomyelitis. Each disease is presented with a discussion of etiologic agent, pathology involved, clinical manifestations, prophylaxis, and treatment.

A rather extensive section is given over to the principles and details of the management of contagious diseases in the hospital, home, boarding and day schools. This is of practical value, particularly to school health and public health personnel.

That the text has been revised to current developments is evidenced by the inclusion of a chapter on sulfonamides and antibiotics. Reference to the use of the antibiotics in the therapeutic armamentarium is included under the specific diseases.

The book is a useful addition to the library of the medical practitioner, and those in the field of public health—whether physician, nurse, or members of allied professions who have occasion to deal with the diseases discussed.

—EDWARD W. COLBY, M.D., *Director, Division of Communicable Disease Control, State Department of Health, Concord, New Hampshire.*

AUDIO-VISUAL AIDS IN THE ARMED SERVICES

By John R. Miles and Charles R. Spain. Washington, D.C., American Council on Education, 1947. 96 p. $1.25.

Any veteran of World War II will attest the effective use of audio-visual aids in training. Civilian professors who witnessed the educating of millions in the Armed Forces of the United States were appalled with the rapidity and thoroughness with which it was accomplished. Everyone had to marvel at the abundance, variety, and completeness of the training aids and were aware of the resourcefulness of those who devised and used them. Certainly the combined talent and efforts of the teacher, advertising and publicity experts, movie producer, engineer and manufacturer—plus the impetus of war—gave us audio-visual aids that exceeded anything that was known in the prewar classroom. No single book could be written that would do justice to all phases of this subject.

The present volume gives a bird's-eye view of the crying need of adequate audio-visual aids for training large numbers of hurriedly mobilized troops. It gives a glimpse of the problems of improvising, producing, and distributing such aids, and of training instructors to use them correctly. This book is an ex-

cellent resumé of the overall problems of the need, procurement, and usefulness of audio-visual aids.

If one is interested in the actual technics of using a large variety of audio-visual aids, one will be disappointed in the limited treatment of this phase of the subject in the text. The few illustrations mentioned in the book hardly do justice to all the manuals, handbooks, circulars, bulletins, pamphlets, posters, charts, models, photographs, maps, cartoons, diagrams, slides, films and other pictorial materials. Demonstration and practice devices are given brief consideration, although they were often so elaborate and costly that nothing like them could be duplicated in the ordinary classroom.

A challenge is proposed in the final chapter which is worth consideration by every civilian teacher. Veterans of the Armed Services who are now taking advanced training in colleges and universities are finding themselves subjected to antiquated methods of instruction. Doubtless there are many professors who themselves need some advanced training in the modern methods of education.

—WILLIAM W. STILES, M.D., *Associate Professor of Public Health, Chairman, Audio-Visual Aids Committee, University of California, Berkeley 4, Calif.*

HOW TO HELP YOUR HEARING

By Louise M. Neuschutz. New York, Garden City Publishing Company, 1947. 171 p. $1.00.

"Oh, you're hard of hearing too!" is an observation that often initiates better understanding by a person who suddenly loses his hearing. Louise Neuschutz who has been hard of hearing for years has helped many persons similarly handicapped and her book offers new advice to the hard of hearing.

The book is replete with inspiring suggestions, promises and explanations that permit one to proceed to self-help with the same determination that brought successful living to the author. In a business-like manner, she tells in the first section of the book how to meet the problem; in the second section, how to adjust oneself; in the third, how to keep mentally and physically fit; in the fourth, how to be good company to oneself; and in the fifth, how people with normal ears can help people with reduced hearing.

One of the commonest and most necessary instructions that teachers give to those suddenly handicapped is to face the facts—and act. This is good advice both for the individual and for the parents and friends of such persons. Inability to face the fact keeps one handicapped. Accepting the handicap permits one to climb to untold heights of happiness and success, material, spiritual or both. Compensation makes up for physical limitation; eyes help ears; science gives wires and amplification for better hearing.

How one adjusts to the world is subtly told by revealing stories of numerous young and old who did it the hard way, by work, by study, and by determination. The art of being deaf, relates Miss Neuschutz, is to learn to get along naturally and gracefully in a hearing world, while at the same time make the silent moments golden.

The complexes of fear and worry, of suspicion and morbidity, inattention, and escapes from reality can be avoided by helping others and by riding a hobby horse or two.

This book should be read by every hard of hearing person and by parents of such children. The public health nurse can guide and inspire the handicapped by using suggestions offered in this valuable book.

—WARREN H. GARDNER, PH.D., *Chief, Hearing and Speech Therapy Division, The Cleveland Hearing and Speech Center, Cleveland, Ohio.*

SCHOOL HEALTH PROBLEMS

By Laurence B. Chenoweth and Theodore K. Selkirk. Third Edition. New York, F. S. Crofts & Co., 1947. 419 p. $3.00.

Public health nurses working in schools, school administrators, and students of school health problems will find a great deal of helpful material in the third edition of this book which has already been found valuable by these groups in its two previous editions. The practical experience of the authors enables them to present their scientific material in an effective and usable form.

The chapters on growth have been enriched and methods of measuring visual and hearing acuity are discussed more fully.

One regrets that the references following each chapter which were one of the most valuable features of the first edition in 1937 have not received more attention in the revision process. It seems surprising that the latest references on such subjects as "endocrine glands" and "malnutrition" would be dated

1938; that a 1930 reference would be given for "control of ringworm"; and that softening nits with vinegar and cutting hair short are recommended for pediculosis. In the discussion of epilepsy no encouragement is given for keeping pupils in school who are under effective treatment, nor is any mention made of the materials on the subject available from the National Association to Control Epilepsy. In the discussion of heart disease and rheumatic fever the work of the American Heart Association is omitted.

In spite of these shortcomings, the presentation as a whole is still the best in the field.

—MARIE SWANSON, R.N., *Supervisor of School Nursing, N. Y. State Education Department, Albany, N. Y.*

THE RANKS OF DEATH

By P. M. Ashburn. New York, Coward-McCann, 1947. 298 p. $5.00.

This medical history of the conquest of America is one of the few books that gives the viewpoint of medicine and the influence of disease and health upon human affairs. The author is eminently qualified, both from experience and by profession, to write with authority. The impact that disease had on the whole course of events in half a world is told in clear and interesting fashion. Written as a studious work, carefully documented, the story reads like an absorbing work of fiction. Scholarly description is given of the actual results of diseases, and their effects on the conflict which determined the fate of two continents. With reference to the red men, the author writes, "Nowhere did the Indians get quite fair-play, and in no respect were they greater sufferers than from the white man's diseases, which they had not known before."

—JOHN B. SETZLER, M.D., *Senior Health Officer, Director, County Health Department, Spartanburg, S. C.*

THE UNCONQUERED PLAGUE

By Harry Wain. New York, International Universities Press, 1947. 119 p. $1.50.

This story of gonorrhea is simply and frankly told. Although written for the intelligent layman it is of value to the professional worker. The historical background, tracing the infection from about 5,000 B.C., emphasizes its antiquity and persistence. The gonococcus described fully as a "Crippler of Men," "Wrecker of Women," and "Blinder of Babies," takes its place with other better known and more respectable organisms which have plagued mankind. No effort other than giving the factual information is made to dramatize this fact. The paragraphs on gonorrheal vaginitis might be questioned by other authorities; otherwise there is no conflict with present-day knowledge. A discussion of the various ineffective methods of treatment makes the reader thankful for the wartime progress in the use of penicillin. In the last three chapters the challenge of control, recognizing all of the inherent social factors, places the responsibility on the community as well as on public health agencies. This book could well be placed in high school libraries as reference material for integrating health into the general curriculum.

—EDITH EYSTER, R.N., *Consultant, Division of Venereal Disease Control, Los Angeles County Health Department, Los Angeles, California.*

CALCIUM AND PHOSPHORUS IN FOODS AND NUTRITION

By Henry C. Sherman. New York, Columbia University Press, 1947. 176 p. $2.75.

This book is welcomed by workers in nutritional chemistry. Professor Sherman reviews the research of calcium and phosphorus for the past 40 years. He includes in the book reports on his own splendid research and, also, that of other investigators. From the large amount of evidence over many years Professor Sherman summarizes the need for calcium in this sentence: "One gram of food calcium is a desirable part of the daily food supply of everyone, with probably somewhat more in the years from ten to twenty, and certainly substantially more in the latter half of pregnancy and during lactation."

This book will be of value to students, teachers and public health workers in nutrition. The tables and figures contribute greatly to the interpretation of the benefits derived from liberal intakes of calcium and phosphorus along with other nutrients in optimum amounts. The selected bibliography is of particular value to the student who wishes to do further reading.

—L. MARGARET JOHNSON, *Associate Professor of Nutrition and Chemistry, George Peabody College for Teachers, Nashville, Tennessee.*

YOUR CARRIAGE, MADAM

By Janet Lane, New York. John Wiley & Sons, Inc., 1947. 160 p. Second edition. $2.50.

The title of Miss Lane's book has various connotations, but it is written specifically about your posture. The material is presented in the vernacular, and illustrations in caricature provide good visual aids in emphasizing the content. The book is written in two parts: The Shape You Are In and Grace Without Groans. The chapter headings are equally individualistic and descriptive.

The characteristics of potentially graceful carriage falling into disgrace are well presented. The dilemmas of bulges, fatigue, and freak diets are attacked. Clothing and shoes for comfort and efficiency are discussed. Good, simple material is presented in relation to body alignment and body mechanics, as they should be considered in daily activities at work and play. Points of caution and suggestions regarding self-correction are well taken.

Although the book was written for the layman and the author compliments the "trained nurse who can turn mattresses and lift heavy patients painlessly," it is believed that the professional nurse could find many valuable suggestions in the book for maintaining or obtaining a sense of well being.

—Lucy E. Blair, *9 West 102 Street, New York City.*

RECENT PUBLICATIONS AND CURRENT PERIODICALS

GENERAL

Directory of Convalescent Homes in the United States. Prepared under auspices of Committee on Public Health Relations of N. Y. Academy of Medicine. Copies may be purchased from the Burke Foundation, White Plains, N. Y. 6th edition. 1947. 112 p. Price 50c.

Buying Your Own Life Insurance. By Maxwell S. Stewart. Pamphlet No. 134. Public Affairs Committee, 22 East 38th Street, New York 16, 1947. 32 p. Price 20c.

Fatigue and Impairment in Man. By S. Howard Bartley and Eloise Chute. 429 p. McGraw-Hill Company, New York, 1947. $5.50.

Facts About Nursing, 1947. 10th edition. 74 p. Price 35c.

Educational Funds for Student Nurses and Graduate Nurses. 1947. 16 p. Free.

The above publications are available from the Nursing Information Bureau, 1790 Broadway, New York 19.

Scheduled Salaries for Social Work Positions in Hospitals in New York City. By Ralph G. Hurlin. 42 pp. Russell Sage Foundation, New York. March 1947. Price 40c.

Includes data on related conditions of employment.

NURSING EDUCATION

Diagnostic Bacteriology. By Isabelle Schaub and M. Kathleen Foley. C. V. Mosby Company, St. Louis. Third edition. 1947. 532 p. $4.50.

Laboratory Manual of Microbiology for Nurses. By Elizabeth S. Gill and James T. Culbertson. G. P. Putnam's Sons, New York. 1947. 116 p. $1.50.

Guide for an Advanced Clinical Course in Tuberculosis Nursing. Prepared by Subcommittee on Tuberculosis Nursing of the Committee on Postgraduate Clinical Nursing Courses. National League of Nursing Education, 1790 Broadway, New York 19, 1947. 17 p. Price 60c.

Study of Pediatric Nursing. Sponsored by the U. S. Children's Bureau and the National League of Nursing Education in cooperation with New York Hospital. National League of Nursing Education, 1790 Broadway, New York 19, N. Y. 1947. 112 p. $1.50.

Textbook of the Nervous System. By H. Chandler Elliott. J. B. Lippincott Company, Philadelphia. 1947. 384 p. $8.00.

INDUSTRIAL HEALTH

Guide to Industrial Accident Prevention through a Joint Labor-Management Safety Committee. Bulletin No. 86. 1947, 11 p. U. S. Department of Labor, Division of Labor Standards, Washington 25, D. C. Limited number of copies free.

Industrial Safety Chart Series. For posting in employee training programs, in plants, shops, schools, etc. The series include such topics as drill presses, grinding wheels, electrical equipment, and many others. Send for complete list. Issued by the Division of Labor Standards, U. S. Department of Labor, Washington, D.C. Free copies available in limited quantities on request.

Metropolitan Services in Industrial Health and Safety. Metropolitan Life Insurance Company, N. Y. May 1947. 24 p. Free.

NOTES FROM THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

1947 REVIEW OF AGENCY MEMBERS

In September 1947 NOPHN began a periodic review of agency members. As planned at present, about one third of the agencies will be reviewed each year, making it possible to reach all agencies every three years. Purpose is to provide a way for NOPHN to help its member agencies promote and maintain accepted standards of public health nursing organization and practice and to keep NOPHN informed about national progress in public health nursing.

Almost all the agencies receiving the 1947 Periodic Review form returned it promptly. A summary of those received follows:

Nearly all agencies have written personnel policies and nursing policies and procedures. These are periodically reviewed and kept up to date. Personnel policies are receiving frequent attention because salaries are constantly being revised upward not only to get them where they should have been long ago but more recently to keep pace with rising living costs. Many agencies have classified their public health nursing positions in terms of preparation and have established minimum and maximum salary ranges with a provision for periodic increments. This is an important step in securing and keeping nurses today. Almost all agencies have adopted retirement plans for their staffs. More and more agencies are operating on a 5-day-40-hour week. Agencies at their own cost or sharing half the cost require preemployment and annual health examinations including chest x-rays. The agency's own health examination form is used, in general, whether the physician is chosen by the agency or the nurse.

Requirements for the various public health nursing staff positions are less frequently a part of the personnel policies. There was little response to the request for requirements for the supervisory and executive nursing positions. This raises the question as to whether the nursing director and nursing committee have studied desirable qualifications for presentation to and adoption by their boards of directors. Certainly board decision as to personnel policies including qualifications of all personnel is important. Many agencies have adopted NOPHN recommended qualifications for public health nursing personnel—sometimes with slight modifications—with the statement that they apply to new appointees. With the shortage of nurses today, it sometimes is not possible to secure qualified personnel. However, it is important for the nursing committee and the board to be aware of the kinds of personnel they are seeking even if persons with desirable qualifications are not readily available.

JTNAS PROGRAM ENDORSED

The Council on Tuberculosis Nursing, which acts in an advisory capacity regarding policies, programs, and projects of the Joint Tuberculosis Nursing Advisory Service, met on December 10, 1947.

At this meeting the JTNAS program for 1948 was studied and it was voted that the Council endorse the activities of JTNAS as making an essential contribution to the field of tuberculosis nursing; that it endorse the program and budget for the ensuing year and request the appropriation of funds to continue the work from April 1, 1948 to March 31, 1949.

JTNAS, which functions for both the NLNE and NOPHN, plans a greatly enlarged program for 1948.

CONFERENCE ON FAMILY LIFE

NOPHN is among the 112 organizations sponsoring the National Conference on Family Life to be held May 6-8 at Washington, D. C. The sponsoring groups comprise doctors, nurses, lawyers, businessmen, labor, clergymen, housewives, teachers, social workers, professors, and young people,—40,000,000 in all.

President Truman has endorsed the objectives of the conference and offered the White House as a meeting place. The six general subject headings of the conference will be education, health and medical care, social welfare, guidance, and legal services; housing, home management, and community planning; economic factors; and inter-personal relations and mental hygiene.

NEW JONAS GUIDE ISSUED

The Joint Orthopedic Nursing Advisory Service has recently issued a mimeographed guide *Suggestions for Orthopedic Institutes or Group Conferences.* Although this material deals primarily with orthopedic institutes or group conferences, it is practical for use in planning institutes in other fields of nurs-

ing, such as pediatrics or mental hygiene. Topics covered are sponsorship of institutes, membership of planning committee, definite functions of each committee, length of conference, and the selection of registrants. The need for providing practice or discussion periods for small groups to augment the sessions devoted to lectures or demonstrations for larger numbers is stressed.

Methods of program planning and program selection are illustrated, and an appendix gives a sample program. This outlines main and subtopics, suggests methods of presentation, and indicates specialists usually found in any large community. Such specialists might be expected to make the best presentation of material.

Single copies of the guide may be obtained free of charge by writing to the Joint Orthopedic Advisory Service, 1790 Broadway, New York 19, N. Y.

NOPHN FIELD SCHEDULE

Staff Member	*Place and Date*
Ruth Fisher	Chicago, Ill.—Feb. 6, 7
	Salt Lake City, U.—Feb. 9-14
Sarah A. Moore	Chicago, Ill.—Feb. 11-14
Jessie L. Stevenson	Hartford, Conn.—Feb. 2-4
	Boston, Mass.—Feb. 5-11
	Philadelphia, Pa.—Feb. 23
Louise M. Suchomel	Montreal, Can.—Jan. 26-Feb. 4
Alberta B. Wilson	Boston, Mass.—February

Field trips to Washington, D. C., were made in January by Anna Fillmore, M. Olwen Davies, and Edith Wensley. Katharine Amberson visited Philadelphia during that month.

WHAT MEMBERS AND FRIENDS ARE DOING

Margaret Wolcott has been appointed director of nurses of the Cortland County (N. Y.) Health Department. . . . *Mary Luvisi* has succeeded Elizabeth Reed as director of the VNA of Jacksonville (Fla.). . . *Dr. J. A. Curran,* NOPHN Board member, was decorated with the Order of the Shining Star in recognition of significant contributions to medical aid to China. . . . Among 48 members elected to the council of the National Committee for Mental Hygiene were *Elizabeth G. Fox,* executive director, VNA, New Haven (Conn.) and *Dr. Ira V. Hiscock,* professor and chairman, Department of Public Health, Yale University, New Haven (Conn.) and member of NOPHN Board. . . . *Petronilla Commins* is now instructor in public health nursing at Incarnate Word College, San Antonio (Tex.). . . . *Thomas Devine* became executive editor of *Survey Midmonthly,* national magazine of social work, in October. . . . *Lucile Petry,* chief of the Division of Nursing of the USPHS and director of the Cadet Nurse Corps, was chosen for "*Look* Applauds," published in *Look* Magazine December 23, 1947. . . . *Dr. Martha Eliot,* associate chief of the U. S. Children's Bureau, has received the *Parents' Magazine* Medal for Outstanding Service to Children. . . . *A. Betty Updegraff* has succeeded Alice V. Hagelshaw as assistant professor of Public Health Nursing, Simmons College, Boston. . . . *Theodora Sharrocks* is the new director of the Yonkers (N. Y.) VNA. . . . *Jeannette B. Vroom* is now field coordinator in public health nursing at the School of Public Health, University of Minnesota. . . . *Leone Ware,* most recently advisory nurse in the Illinois State Department of Health, has retired from active public health nursing after 26 years of service. . . . *Mrs. Emily K. Johnson,* former public relations director for the Nursing Information Bureau, is to assist in the expanded nurse recruitment program of the American Hospital Association. . . . *Mildred Cardwell,* supervisor of nurses, Lansing-Ingham County Health Department (Mich.), was installed as president of the Michigan Public Health Association in November. . . . *Dr. William A. Brumfield,* director of the Division of Venereal Diseases of the New York State Health Department, has been appointed deputy state commissioner of health.

Claudia Crownover has been appointed to the new National Blood Program as ARC Southeastern Area Supervisor of Centers Nurses. Miss Crownover will assist in the development of a training program for nurses employed in the national blood program centers and mobile units. . . . *Virginia Elliman,* American Red Cross nursing director of Eastern Area office, Alexandria (Va.), has been awarded the first Clara Dutton Noyes scholarship since World War II. The scholarship includes a three-month study period in Europe, beginning after January 15, 1948. . . . *Nora Marco,* training supervisor, Pacific Area, at present is spending a few months in Alaska assisting local Red Cross chapters in the preparation of home nursing instructors. . . . *Ellen Aird,* educational consultant in home nursing, ARC national headquarters, left for Puerto Rico in January to carry out a similar home nursing education program in the Puerto Rico chapter in conjunction with Rafaela Morales, chapter nursing director.

NEWS AND VIEWS

On Nursing

NEWS LETTER FOR STRUCTURE COMMITTEE

The committee on the Structure of National Nursing Organizations will issue a news letter to nurses throughout the country several times during 1948.

This new occasional periodical will serve the dual purpose of reporting to nurses promptly the progress of the structure program, employing newspaper technics as far as possible, and replacing the Workshop Guides of 1947.

The first issue will offer suggestions for discussion of the following five "green lights": (1) planning ways in which an effective organization for nursing education and service can be developed (2) planning ways for ANA to absorb the functions of NACGN (3) formulating recommendations for unification of industrial nursing interests with organized nursing (4) seeking an acceptable plan for non-nurse membership and (5) proposing appropriate relationships between professional and practical nurse groups.

Hortense Hilbert, chairman of the Committee on Structure, has found the opinions and ideas expressed last year invaluable. She hopes that with continuing widespread participation in the program the proposals to be made by the Committee can be shaped in accord with the wishes of nurses throughout the country.

"We shall hope," said Miss Hilbert, "that thinking on at least some of the aspects will mature rapidly enough to permit decisions at the Biennial next June. The problems facing nursing today will not wait. We must have efficient organizational machinery for dealing with them as a profession."

An extensive free mailing list is being developed for the news letter. Requests for inclusion on it will be welcomed by the Committee on Structure at its office, Room 201, 1790 Broadway, New York 19, N. Y. The Committee is encouraging every recepient to share the contents of each issue with at least 10 other nurses.

ABOUT THE BIENNIAL

The Joint Committee on Program has chosen as the theme for the 1948 Biennial Nursing Convention: *America's Nursing Care—A Professional Challenge and a Public Responsibility.* It is the belief of the Committee that with this theme, programs may be developed which will prove inspirational and educational and place emphasis on the service given by the nursing profession to the patient and to the community.

Tentatively planned are one joint program stressing the responsibility of the individual in a world society, another devoted to educational aspects, and the third to community planning for nursing care.

Rose Coyle, director of nursing, Margaret Hague Maternity Hospital, Jersey City, N. J., is chairman of the ANA Committee on Transportation. Railroads will not offer reduced rates, and in view of present travelling conditions, Miss Coyle suggests that all conventioners make early reservations.

All groups planning breakfast, luncheon, or dinner meetings are asked to make their own arrangements with the hotels and to be responsible for selling tickets. Details of such arrangements will be provided at the information booth during the week of the convention. Minimum prices of meals at the headquarters hotels (plus 2 percent sales tax and 10 percent gratuity) are:

Hotel	*Breakfast*	*Luncheon*	*Dinner*
The Stevens	$2.50	$2.50	$2.50
Palmer House	2.50	3.00	4.00
Congress	—	2.50	3.75

Exhibits will be housed in the Exhibition Hall at The Stevens, and the program has been planned to permit as much time as possible for visiting them. This is one of the most outstanding features of the convention, and all nurses are urged to acquaint themselves with the latest nursing equipment, infants' foods, textbooks, and many other items of professional interest.

NEW PEDIATRIC NURSING STUDY

A Study of Pediatric Nursing, sponsored by the U. S. Children's Bureau and the National League of Nursing Education in cooperation with the New York Hospital, New York City, is now available.

This is primarily a study of the nursing care given to children in a hospital, but it has important implications for all nursing education. It will be of interest to faculties of schools of nursing as well as to public health nursing agencies and other nursing service personnel. The study may be obtained from the National League of Nursing Education, 1790 Broadway, New York 19, N. Y. Price $1.50.

From Far and Near

● The theme of 34th National Negro Health Week, to be observed April 4-11, 1948, will be "A Practical Health Program for Myself and My Family: Learn what you ought to know—Health Education; Do what you ought to do—Healthful Living." Information may be secured by writing to: National Negro Health Week Committee, Federal Security Agency, Public Health Service, Washington 25, D. C.

● The 24th Annual Convention of the International Council for Exceptional Children will be held in Des Moines, Iowa, April 25-28, 1948.

Convention headquarters will be at Hotel Fort Des Moines. Individuals desirous of attending this convention of educators, health and social workers interested in the problems of the handicapped child should make reservations early by writing to Mrs. Betty Whitford, 629 Third Street, Des Moines, Iowa.

● The American National Red Cross offers excellent employment opportunitites for graduate nurses as instructors and field representatives. Opportunities are also being offered to nurses under the National Blood Program now being launched. Openings are available in various sections of the country. Salaries are commensurate with training and experience. Inquiries should be directed to Mr. Norman A. Durfee, Administrator for Personnel Services, National Headquarters, American Red Cross, Washington 13, D. C.

● Two positions are now open in the State Department of Health, Wisconsin. A public health nurse and advisory public health nurse, beginning salaries $160 and $210, respectively are needed. Both positions require that applicants be registered in Wisconsin or eligible therefor, and that they be certified as public health nurses in Wisconsin. Apply to the Bureau of Personnel, State Capitol, Madison 2, Wisconsin.

● During the period June 11-22, 1948, Catholic University of America will offer a workshop on the Mental Health Aspects of Nursing, with emphasis on ways and means of incorporating mental health principles in all areas of nursing. For further information write to Theresa G. Muller, Coordinator in Psychiatric Nursing, School of Nursing Education, Catholic University of America, Washington 17, D. C.

● Dr. Neil P. Macphail, veteran surgeon and sanitarian of the United Fruit Company at Quirigua, Guatemala, was awarded the Richard P. Strong palladium medal for distinguished service in tropical medicine at the annual dinner of the American Foundation for Tropical Medicine, held January 8th at the Waldorf-Astoria, New York. Sarah A. Moore represented the NOPHN.

● Inadvertently the name of New York University was omitted from the paragraph describing the new department of graduate nursing education in that institution, of which Dr. Vera S. Fry is chairman-director. The newsnote appeared in the December 1947 issue, page 637.

Case Finding in Cancer Centers—During a period of 9 months, 1,709 persons were examined in cancer detection centers in Maryland. Of these 336 were men and 1,373 women, according to H. W. Jones and W. R. Cameron (*Journal of the AMA*, December 13, 1947).

By means of the expected prevalence and detectability rates developed by Dorn, it is calculated that 0.56 case would have been expected in the male and 4.9 cases in the female examinees. Actually 8 carcinomas were found among the men and 9 among the women. These figures, as well as those collected from the literature, show a prevalence rate of 10 to 15 times that expected in males and 2 times the expectancy in females.

These data seem to indicate that there are factors at work in the selection of the type of patients presenting themselves for examination in cancer detection centers. Evidence suggests that one factor may be the presence of minor complaints and another the occurrence of cancer in the immediate family of the examinees. An incidental, but important, finding was that 36 percent of men and 51 percent of women examinees were referred to their physician because medical or surgical conditions other than cancer were discovered.

Study of Vision-Testing Methods—Many long-debated questions on vision-testing will be on the way to solution at the completion of a project soon to start in St. Louis, Missouri.

The Division of Research in Child Development of the Children's Bureau invited the National Society for the Prevention of Blindness and cooperating agencies to participate in a study of vision testing. The purpose of the study is to evaluate practical methods of vision testing suitable for use by school teachers or school nurses. About 1,200 children will receive not only the routine vision tests given by

teachers or nurses, but an eye examination by an eye physician in Washington University Eye Clinic in St. Louis. Comparison of results will show which testing methods are most efficient, and how accurate each test is in comparison with the eye physician's complete examination.

The study, in addition to examining methods, will consider the question as to whether teacher, nurse, or special technician should conduct tests. Technical guidance will be furnished by an advisory committee of ophthalmologists with Dr. William L. Benedict, chief ophthalmologist of Mayo Clinic, as chairman.

A report of the study will be made and recommendations made available. These, it is hoped, will lead to a more uniform and practical procedure in the testing of school children's eyesight.

Trends in Syphilis Control—The development of rapid treatment facilities, which could not be forecast in 1937, has been one of the most striking phenomena in contemporary syphilis control, states J. R. Heller, Jr., M.D., chief of the VD Division of USPHS (*Journal of Venereal Disease Information*, November 1947). Originally established in 1943 as a wartime emergency measure to provide intensive therapy for large numbers of patients with infectious syphilis and gonorrhea, the rapid treatment centers were in a strategic position for adaptation to broad-scale introduction of penicillin therapy. The nation's rapid treatment facilities have expanded to include beds in general hospitals and are now treating approximately 150,000 cases of syphilis a year—representing more than one third of all syphilis cases reported, and more important, including a major portion of all cases of early syphilis treated.

In 1937, not a single state in the Union required antepartal blood tests. Connecticut's premarital law was only 2 years old, and five more states were enacting laws requiring premarital examination laws. Today, 36 states have premarital examination laws, and 35 states and one territory require antepartal tests for syphilis. At present premarital and antepartal blood tests are performed at a rate of about 2,500,000 a year, resulting in the discovery of thousands of cases of syphilis per year. The 60 percent reduction in infant deaths due to congenital syphilis during the decade may be attributed in large part to the fulfillment of the basic requirement of antepartal and premarital serodiagnostic tests.

Diphtheria Fight Continues—Diphtheria, on the rapid downward trend up to 1940, increased during war and postwar years until in 1945 there were almost 19,000 cases and 1,600 deaths, and in 1946 over 16,000 cases and 1,300 deaths. During the first 6 months of 1947, reports the September 1947 *Statistical Bulletin* of MLI, there was a decrease in the number of cases.

States which have shown especially large increases since 1940 are Minnesota, Maryland, Massachusetts, New York, Washington, California, and Florida. Notable among those showing decreases are District of Columbia and Oklahoma. Public health workers are now aroused to the situation and are taking steps to remedy it.

"Diphtheria can be wiped out," concludes *Statistical Bulletin*. "This goal can be attained only if all the states set up and maintain a coordinated program of prevention. Special efforts need to be made in those areas in which the percentage of immunized school children is low. Immunization clinics conducted by local health departments in cooperation with the schools should be a part of every program. This will insure completion of the initial immunizations and booster doses of toxoid in accordance with the current recommendations of pediatricians. And the great number of young mothers harboring a false sense of security regarding diphtheria must be impressed with the danger of allowing their young children to go unprotected against the disease. The eradication of diphtheria is a job which can be done, but everyone must play his part in doing it."

Effects of War on Child Health—A significant feature of the recent war, states Professor Richard W. B. Ellis, University of Edinburgh, in *Proceedings of the Staff Meetings of the Mayo Clinic*, October 1, 1947, was the attention paid in almost every country to the protection of child life during the war years. In previous wars children have more or less taken their chances with the general population, their needs likely to be met last rather than first. Physical and psychologic effects of total war on children, states Professor Ellis, are those due (1) to mass refugee movement (2) to enemy occupation and (3) those for which prolonged aerial bombardment is primarily responsible.

The physical hardship of refugee movement, he believes, is rather quickly forgotten, but the insecurity of having no settled home, no personal possessions, and no permanent friends, gives the refugee child a handicap which can never be completely overcome.

Among Spanish children evacuated to England, the most significant epidemic diseases were found to be typhoid fever, pulmonary tuberculosis, pediculosis, impetigo, and scabies. Severe nutritional deprivation and crowded air-raid shelters doubtless favored tuberculosis infection. Pediculosis and scabies proved to be large problems in dealing with a childhood population. The discovery and widespread application of DDT. however, prevented the major world disaster which pediculosis threatened. Authorities believe that cutaneous sepsis from pediculosis and scabies may have contributed to widespread osteomyelitis as much as malnutrition.

The child in an enemy-occupied territory must live by two standards of behavior: that of the occupying power, and that of the patriot. It is impossible to assess the permanent effects of such an

enemy occupation on the social attitudes of children exposed to this double standard during their formative years. They were required to bear a burden which broke many an adult back. Certainly return to normal standards was made difficult. The effect of enemy occupation on nutrition and growth of children, more tangible, was found similar to the effect of a period of economic depression. In Belgium early recognition of the dangers of deprivation to children resulted in priority and special rations for infants and school children.

The effects of prolonged aerial warfare, other than loss of life, states Professor Ellis, are related to evacuation of children from danger areas to reception areas; observance of a rigid blackout, and living conditions in air-raid shelters.

Evacuation involved large-scale inspection and cleansing facilities, billeting, reorganization of social services and food and milk supplies. The child who was unsuccessfully billeted sometimes became a behavior problem, and children's colonies had to be established for those whose behavior became such as to render them unbilletable.

As far as possible, infants and preschool children were kept with their mothers, but as the bombardment was intensified and more women were drafted into war work, nurseries and nursery schools had to be set up. Outbreaks of various infections had been expected upon the inception of this program, but except for serious gastroenteritis, the infection rate was not nearly as high as had been expected. The lack of ventilation in hospitals and nurseries during the blackout was another deplorable feature. The use of air-raid shelters for long periods of time exposed children to loss of sleep, overcrowding in vitiated air, continual contact with adult anxiety, and cross infection.

Two important measures were taken by England to preserve child health (1) the National Milk Scheme whereby each child received safe milk regardless of economic level and (2) the provision of school meals, making it possible for all school children to obtain an adequate noon meal at low cost and with minimum waste of the national food supply.

Advertising Readership Formula—Seven points to aim at in order to produce high readership of advertising have been outlined by admen who handle A & P foodstores accounts, as reported in *World-Telegram*. The seven-point formula of how to build a food ad reads: (1) Women, particularly housewives who buy food, are more interested in pictures of finished foods (ready for the table) than those of raw foods, or foods displayed for sale. (2) They are more interested when the foods are shown in full color with interesting and attractive accessories such as dishes, silverware, linen. (3) They are interested in prices. (4) They are also interested in menus and recipes to help them plan meals. (5) More women will as a rule stop to look at an advertisement containing a single large picture than one with several small pictures. (6) They are more likely to read the ad text if its head is of a service-benefit nature rather than of glorification of the product or maker. (7) More will read the ad if it is simple and easy to follow.

When this formula was applied, readership figures showed a jump from 55 to 81 percent of those who "saw" the ad and from 14 to 32 percent who "read thoroughly" compared with a previous ad in the same publication. Store sales rose 24.5 percent for the products mentioned in the ad.

Commercial advertising technics have their lessons for those in health and social welfare. Some of the above principles can well be applied to public health nursing leaflets, posters, and other materials designed to reach the public.

Trends in Consumption of Major Food Groups—The most notable changes in food consumption during the period 1909-1945 are the upward trends for dairy products (excluding butter), citrus fruit, and leafy, green, and yellow vegetables; and downward trends for potatoes and grain products. According to Faith Clark, Berta Friend, and M. C. Burk of the U. S. Department of Agriculture (Miscellaneous Publication No. 616) no general trend in the per capita consumption of eggs is evident, but wartime shortages of meat caused record egg consumption in 1945.

The consumption of fats and oils, including butter, bacon, and salt pork, was comparatively stable after 1923 when it reached a slightly higher level than in the preceding 15 years. Until war restricted supplies, shortening and cooking and salad oils were becoming increasingly important. During 1941-1945 margarine became widely used as a butter substitute.

The downward trend in consumption of potatoes and sweet potatoes is one of the most striking changes in food consumption. Per capita use of potatoes declined a third and sweet potatoes a fourth from 1909 to 1945. The use of dry beans, peas, and nuts increased markedly in the two war periods.

Consumption of fruits other than citrus and of vegetables, other than the leafy, green, and yellow ones, has shown no definite trend for the group. However, use of canned vegetables has increased and consumption of apples has declined. From 1909 to 1930 consumption of sugar increased; in the mid thirties this declined, rising in 1941 only to drop again during the war years. Sirups, largely made from starch derivatives, were used to replace sugar when it was in short supply.

Tea and coffee habits also have changed. These items, though unimportant nutritionally, are a part of the national food supply. Tea consumption has declined and coffee consumption increased since 1909. Use of cocoa, too, was on the upswing until checked by the war.

VIAL OF 4 cc.

A Long Step Forward

in the *Specific Treatment* of whooping cough

ANTIPERTUSSIS SERUM (Rabbit)

WYETH

HIGHLY CONCENTRATED...PRECISELY STANDARDIZED

Each dose...4 cc. ...contains therapeutic concentrations of antibodies and not less than 20,000 units of antiendotoxin.

Inhibits growth of Haemophilus pertussis and neutralizes its endotoxin... Imparts a temporary immunity to contacts, modifies and shortens the active disease . . . Tends to prevent complications.

PERTUSSIS ENDOTOXOID-VACCINE Wyeth, for active immunization, contains 15 billion killed H. pertussis and 140 provisional units of pertussis endotoxin per cubic centimeter, converted to endotoxoid.
The endotoxoid component stimulates production of antiendotoxin, and the vaccine content provides antibacterial factors against the invading organism itself.

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